National Library of Canada

Acquisitions and Bibliographic Services Branch

395 Wellington Street
Ottawa, Ontario
K1A 0N4

Bibliothèque nationale du Canada

Direction des acquisitions et des services bibliographiques

395, rue Wellington
Ottawa (Ontario)
K1A 0N4

Your file Votre référence

Our file Notre référence

NOTICE

The quality of this microform is heavily dependent upon the quality of the original thesis submitted for microfilming. Every effort has been made to ensure the highest quality of reproduction possible.

If pages are missing, contact the university which granted the degree.

Some pages may have indistinct print especially if the original pages were typed with a poor typewriter ribbon or if the university sent us an inferior photocopy.

Reproduction in full or in part of this microform is governed by the Canadian Copyright Act, R.S.C. 1970, c. C-30, and subsequent amendments.

AVIS

La qualité de cette microforme dépend grandement de la qualité de la thèse soumise au microfilmage. Nous avons tout fait pour assurer une qualité supérieure de reproduction.

S'il manque des pages, veuillez communiquer avec l'université qui a conféré le grade.

La qualité d'impression de certaines pages peut laisser à désirer, surtout si les pages originales ont été dactylographiées à l'aide d'un ruban usé ou si l'université nous a fait parvenir une photocopie de qualité inférieure.

La reproduction, même partielle, de cette microforme est soumise à la Loi canadienne sur le droit d'auteur, SRC 1970, c. C-30, et ses amendements subséquents.

Canada

UNIVERSITY OF ALBERTA

CHARACTERISTICS THAT DEFINE CODEPENDENCY

BY

SHARON H. RIJAVEC

©

A thesis submitted to the Faculty of Graduate Studies and Research in partial fulfilment of the requirements for the degree of MASTER OF EDUCATION IN SCHOOL PSYCHOLOGY.

DEPARTMENT OF EDUCATIONAL PSYCHOLOGY

Edmonton, Alberta

SPRING 1993

National Library
of Canada

Acquisitions and
Bibliographic Services Branch

395 Wellington Street
Ottawa, Ontario
K1A 0N4

Bibliothèque nationale
du Canada

Direction des acquisitions et
des services bibliographiques

395, rue Wellington
Ottawa (Ontario)
K1A 0N4

Your file Votre référence

Our file Notre référence

The author has granted an irrevocable non-exclusive licence allowing the National Library of Canada to reproduce, loan, distribute or sell copies of his/her thesis by any means and in any form or format, making this thesis available to interested persons.

L'auteur a accordé une licence irrévocable et non exclusive permettant à la Bibliothèque nationale du Canada de reproduire, prêter, distribuer ou vendre des copies de sa thèse de quelque manière et sous quelque forme que ce soit pour mettre des exemplaires de cette thèse à la disposition des personnes intéressées.

The author retains ownership of the copyright in his/her thesis. Neither the thesis nor substantial extracts from it may be printed or otherwise reproduced without his/her permission.

L'auteur conserve la propriété du droit d'auteur qui protège sa thèse. Ni la thèse ni des extraits substantiels de celle-ci ne doivent être imprimés ou autrement reproduits sans son autorisation.

ISBN 0-315-82061-6

Canada

UNIVERSITY OF ALBERTA

RELEASE FORM

NAME OF AUTHOR: Sharon H. Rijavec

TITLE OF THESIS: Characteristics That Define Codependency

DEGREE: Master of Education in School Psychology

YEAR THIS DEGREE GRANTED: 1993

Permission is hereby granted to The University of Alberta Library to reproduce single copies of this thesis and to lend or sell such copies for private, scholarly or scientific research purposes only.

The author reserves all other publication rights and other rights in association with the copyright in the thesis, and except as hereinbefore provided neither the thesis nor any substantial portion thereof may be printed or otherwise reproduced in any material form whatever without the author's prior written permission.

(Signed) Sharon Rijavec

PERMANENT ADDRESS
#901, 323 - 13th Avenue
S.W. Calgary, Alberta

DATED April 23, 1993 1993

UNIVERSITY OF ALBERTA

FACULTY OF GRADUATE STUDIES AND RESEARCH

The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled CHARACTERISTICS THAT DEFINE CODEPENDENCY submitted by SHARON HELENA RIJAVEC in partial fulfillment of the requirements for the degree of MASTER OF EDUCATION in SCHOOL PSYCHOLOGY.

L. Stewin

Dr. Len Stewin

J G Paterson

Dr. John Paterson

Janis Blakey

Dr. Janis Blakey

April 8, 1993

ABSTRACT

The relationship between codependency, low self esteem and external locus of control are explored within this thesis. The definition, emergence, diagnosis and development of codependency throughout the developmental stages of infancy, childhood and adolescence are presented in a comprehensive literature review. Particular emphasis in placed on the development of self esteem and locus of control throughout these developmental stages.

A sample of 23 subjects, nine males and 14 females, ranging in age from 17 - 49 years from three codependency treatment groups participated in the research. Four questions were studied:
1) do codependent individuals identify with low self esteem?; 2) do codependent individuals identify with an external locus of control?; 3) will there be a significant relationship between low self esteem, external locus of control and codependency?; and, 4) will there be a significant relationship between the I/E Scale and the ICI as they are both measures of locus of control?. These questions were tested empirically using four instruments: the Individual Outlook Test (IOT), Coopersmith Self-Esteem Inventory (SEI), Internal/External Control of Reinforcement Scale (I/E Scale) and Internal Control Index (ICI). To address the first two questions, one-way analysis of variances (ANOVA'S) were used

with the level of significance set at the .05 level. There was a significant difference between the responses of the two groups on the SEI (p = .0001) and the ICI (p = .010). That is, codependents identified with low self esteem and an external locus of control. There were significant correlations between codependency, low self esteem and an external locus of control as measured by the ICI. Results using the I/E Scale were not significant (p = .625) due to the inadequacy of the instrument. Gender effects were also significantly related to the responses on the IOT and SEI.

TABLE OF CONTENTS

CHAPTER I: INTRODUCTION. 1

CHAPTER II: REVIEW OF THE LITERATURE. 9

The Emergence of Codependency 9
Alcoholism - Treatment and Research. . .9
Family Systems Theory 10
The Alcoholic Family 14
Structure. 14
Identity 22
Connectedness. 23
Communication. 25
Stability. 26
Stages of Development. 29
The Development of Self Esteem 49
The Development of Locus of Control 57
Locus of Control and Self Esteem 63
Conclusion 63

CHAPTER III: METHOD AND PROCEDURE. 67

Introduction 67
Subjects 67
Instruments 67
Demographic Checklist 70
Validity of the Checklist 71

The 60 item Individual Outlook Test. . . . 71
Scoring the I.O.T.. 71
Validity of the 60 I.O.T. 72
Reliability of the 60 I.O.T. 72

The External/Internal Control Scale. . . . 73
Scoring the I/E Scale 73
Validity of the I/E Scale 74
Reliability of the I/E Scale 74

The Internal Control Index 75
Scoring the ICI. 75
Validity of the ICI 76
Reliability of the ICI 77

The Coopersmith Self-Esteem Inventory . . . 77
Scoring the SEI 77
Validity of the SEI. 77
Reliability of the SEI. 78

Procedure. 79
Data Analysis. 81

CHAPTER IV: RESULTS 82

Introduction 82
Hypothesis I 85
Hypothesis II 86
Hypothesis III 89
Hypothesis IV 90
Demographic Findings 91

CHAPTER V: DISCUSSION AND LIMITATIONS. 93

Introduction 93
DeLimitations 93
Conclusions 94
Limitations 95
Implications for Practice 97
Implications for Research 101

REFERENCES 102
APPENDICES 111

LIST OF TABLES

Table Number	Page Number	Table Title
1	84	Description of Sample
2	86	One-way ANOVA SEI By Codependent Group (IOT)
3	87	One-way ANOVA I/E By Codependent Group (IOT)
4	87	One-way ANOVA ICI By Codependent Group (IOT)
5	88	One-way ANOVA IOT By ICI
6	89	Correlational Analysis of IOT, IE, ICI, SEI
7	91	One-way ANOVA SEI By ICI
8	92	One-way ANOVA IOT By Gender
9	92	One-way ANOVA SEI By Gender

CHAPTER I

Introduction

Codependency is defined as

> a dysfunctional pattern of living which emerges from our family of origin as well as our culture producing arrested identity development and resulting in an over-reaction to things outside of us and an under-reaction to things inside of us. Left untreated, it can deteriorate into an addiction. (Friel & Friel, 1987, p. 16)

Children of alcoholics are believed to be at the greatest risk for developing codependency as a result of an alcoholic, dysfunctional family of origin and a failure to master the tasks within each developmental stage necessary for psychological well-being. Codependency was introduced within the last twenty years as a new term designed to identify the psychological effects of living with the problem of alcoholism. Alcoholism itself constitutes a significant social problem. Alcohol related deaths are the leading cause of death for those between the ages of 16 and 24, alcoholism is the fourth ranked cause of death (Strong & DeVault, 1989), over "75 million [people] are affected, ... alcoholism costs...over 120 billion a year, every two and one half minutes there is an alcohol related death and...one in three families are affected" (Gravitz & Bowden, 1985, p. 4). There are between 15 and 34 million children of alcoholics, (Gravitz & Bowden, 1985; Beletsis & Brown, pamphlet) half of whom are now adults. Gravitz and Bowden (1985) indicate that alcoholism is an equal opportunity destroyer; "whoever gets in its path is affected" (p. 4). Larson (1983) states that an alcoholic directly affects between 20 and 30 other people. Hemfelt (1989) states that every alcoholic affects at least four other people producing at least 60 million people who may experience inter and intrapersonal difficulties as a result of alcoholism. These difficulties may include substance abuse or relationship problems. Whitfield (1984) indicates that "codependency affects not only individuals, but families, communities, businesses and other institutions, states and countries" (p. 15).

During the past twenty years, the growth of the codependence movement has been rapid. There has been widespread acceptance of the concept, particulary among the helping professions. Codependency has been described as a profound social movement (Gravitz & Bowden, 1985), an epidemic and even as the ultimate tragedy (Hemfelt, 1989). In 1983, the National Association for Children of

Alcoholics began with as few as twenty members; in 1987 its membership had increased to over 7,000. There is currently a Canadian Association for Children of Alcoholics, an Alberta Institute for Codependency as well as numerous Codependence Anonymous (CODA) groups that have developed throughout North America.

There are several difficulties with the concept as it currently exists in the literature as several fundamental issues have not been addressed. Overall, there is a lack of scientific research on which the concept is based. Rather, authors of codependency have documented numerous definitions, have no diagnostic instruments and have identified hundreds of characteristics based primarily on their personal life experiences and clinical practice in the addictions field.

With respect to the definition of codependency, there are numerous definitions cited in the codependency literature. It has been defined as an addiction, (Hemfelt, 1989) a human disorder with a "recognizable pattern of personality traits", a "therapeutic tool for giving family members something to recover from", a "psychological concept" (Cermack, 1986, pp. 1-3); a concept utilized to categorize the problems of women (Van Wormer, 1990) a "simple-minded conceptualization"

(Lisansky Gomberg, 1989, p. 114) and as a disease process "whose assumptions, beliefs, behaviours and lack of spirituality lead to a process of nonliving that is progressively death - oriented" (Wilson Schaef, 1986, p. 6). The definitions presented appear to depend on the author, his/her psychological orientation (ie behavioral, cognitive or systems theory) as well as his/her personal experiences and the experiences of clients. According to Asher and Brissett (1988), " the definitional ambiguity of codependency not only enhances the application and stickiness of the label but also makes any individual resistance to or rejection of the label difficult" (p. 342). Cermack (1986), who espouses a medical definition within the DSM-III-R, states that it is important to have a definition that interfaces with accepted psychiatric concepts, language and diagnostic systems in order for the concept to be reliable and valid. As a result, he states that codependency should be considered a disease; a perspective which has been supported by others as well (Beattie, 1987; Friel & Friel, 1987; Wilson Schaef, 1986).

In terms of diagnostic instruments, several questionnaires and indexes have been developed; however, there has been no one established or accepted method of diagnosis until the development of the 60 item codependency questionnaire termed the Individual Outlook Test (IOT) by Sim. (1991). Prior to the development of the IOT, a codependency checklist, developed by a codependency support group in 1990, identified numerous characteristics under the headings of control and compliance and requested that clients check those characteristics that pertained to their situation as happening always, usually, sometimes, or never. A 32 item index developed by Hawkins (1988) was modified by Ackerman and Gondolf (1991) into a 20 item index.

Cermack (1986) states that to facilitate diagnosis, codependency should be classified as a personality disorder in the Diagnostic and Statistical Manual (3rd Ed.) Revised (DSM-III-R). In fact, in this edition, a new term "self-defeating disorder" (Van Wormer, 1990, p. 60) was introduced; however, due to its controversial nature, it was shelved for further discussion. Cocores (1987) recommends that codependency be diagnosed as an obsessive-compulsive or adjustment disorder. According to Asher and Brissett (1988), the difficulty with diagnosing codependency is that it is done retrospectively; that is, people do not enter into counseling stating that they are codependent but rather, identify certain behaviours that a practitioner may label as codependent. Then, other behaviours become viewed within this framework and clients receive support for this by their practitioner. Asher and Brissett (1988) also state that those reconstructions then serve as self-evidence of codependency. Finally, Van Wormer (1990) states that there is no clinical entity such as codependency and that current diagnosis is based entirely on the "basis of marriage to an alcoholic" (p. 60).

There are numerous characteristics of codependency that have been presented in the literature. Sim (1991) identified 117 descriptors in the codependency literature which she compiled into ten main characteristics. Mellody (1989) indicates that codependency is reflected in problems in relationship to the self and with others; Friel and Friel (1987) refer to characteristics as identity and intimacy difficulties; a codependency checklist (pamphlet) identifies control and compliance patterns and Ackerman and Gondolf (1991) identify seven characteristics including isolation, inconsistency, self-condemnation, control, approval, rigidity and fear of failure. There is little consensus among the authors as to which characteristics define codependency and little or no empirical evidence to support those characteristics cited by authors. Without such criteria, no standards exist for assessing the presence and depth of pathology, for developing appropriate treatment plans, or for evaluating the effectiveness of therapy (Cermack, 1990). Cermack states that most descriptions are anecdotal or metaphoric, neither of which stands up to scientific scrutiny. Cermack (1986) also states that it is important to have a basic diagnosis that consists of specific characteristics because if everyone appears to be codependent, then how can it be considered a disease? (Hall, 1988). Van Wormer (1990) indicates that the ongoing emphasis on the medicalization of codependency is primarily a result of the alcoholism industry that stands to profit considerably if codependency is classified as a disease. Lisansky Gomberg, (1989) states that characteristics are descriptive and impressionistic. Another criticism of the characteristics is their broadness (Asher & Brissett, 1988) in that anyone can identify with at least some of the traits given their ease and range of applicability. Questions arising from this include: does identification with some traits make one codependent; does one have to have a certain number of traits; do certain traits have more power than others; and, to what degree does one have to have them. The characteristics of low self-esteem and external locus of control, have been identified by the majority of authors as indicators of codependency. The purpose of this thesis is to empirically study these two characteristics as they relate to codependency. A sample of 23 subjects from three codependency treatment groups and four psychometric tests, the I.O.T., ICI, I/E Scale and SEI, are used to address the following questions:

1) Do codependent individuals identify with low self esteem?;
2) Do codependent individuals identify with an external locus of control?;
3) Will there will be a significant relationship between external locus of control, low self esteem and codependency?;
4) Will there will be a significant relationship between the I/E Scale and the ICI both of which are measures of locus of control?.

Based on these four questions, four hypotheses are tested. The results are reported and implications are discussed both for research and for clinical practice in the area of codependency.

CHAPTER II

Review of the Literature

The Emergence of Codependency

The concept of codependency has emerged from two areas: the research and treatment of alcoholism and the framework of family systems theory (Van Wormer, 1990).

Alcoholism - Treatment and Research

The field of alcoholism is in itself a relatively new area of research as it was as recent as 1955 that alcoholism was first recognized as a disease by the American Medical Association (Gravitz & Bowden, 1985). Prior to this, alcoholism was viewed as a moral weakness within the individual. Lord et al. (1987) define alcoholism as "an illness characterized by preoccupation with alcohol and loss of control over its consumption such as to lead usually to intoxication if drinking is begun, by chronicity, by progression and by tendency toward relapse" (p. 414). Early treatment focused exclusively on the alcoholic as it was believed that this individual was responsible for the difficulties experienced within the family unit. However, despite the alcoholic's achievement and maintenance of sobriety, family relationships remained dysfunctional and even became worse. In an attempt to understand this, professionals included other family members in treatment. Initially, this involved spouses of alcoholics with considerable research conducted on female spouses of alcoholic husbands. This focus emerged as a result of earlier beliefs within the psychiatric community that wives of alcoholics chose to marry alcoholics in order to satisfy deep unconscious needs of dependence (Van Wormer, 1990; Royce, 1981).

Professionals discovered that spouses demonstrated certain behaviours that seemed to perpetuate the alcohol problem and, unknowingly, prevented the alcoholic from both recognizing the existence of a problem as well as receiving treatment for it. In fact, it appeared that spouses were also actively engaged in the disease process of alcoholism. Consequently, spouses became referred to as enablers or co-alcoholics (Wegscheider, 1981).

Family Systems Theory

Influential in the treatment of alcoholism was the development of family systems theory (Hill & Hansen, 1964; Strong & Devault, 1989; Satir, 1972; Ackerman, 1958) and according to Van Wormer, (1990) "the systems theory approach...revolutionized much of the thinking within...alcoholism counseling" (p. 58).

The premise of this theoretical framework is that family members act together by following rules and roles which help to maintain the equilibrium of the family unit and that "individual problems are viewed as outgrowths of disturbed family communications" (Van Wormer, 1990, p. 58). Richardson (1987) states that every member of a family affects every other family member in some way; nothing happens in isolation. Minuchin (1974) describes the family as a system that operates through transactional patterns; that is, "repeated transactions establish patterns of how, when, and to whom to relate, and these patterns underpin the system" (Strong & Devault, 1989, p. 394). Subsequently, numerous studies were conducted to examine the reactions of all family members to the alcoholic (Jackson, 1954; Bowen, 1978; Meeks & Keely, 1970). As a result, children of alcoholics became identified as being at risk for serious psychological illnesses (Beletsis & Brown, pamphlet) and would "experience a recognizable pattern of interpersonal discomfort and intrapsychic conflicts" (Cermack & Brown, 1982, p. 20) as a consequence of their early family environments. Subsequently, alcoholism became known as a family disease.

As the medical terminology changed in the 1970's and 80's (Gravitz & Bowden, 1985) from the limited term, alcoholic, to the more inclusive term, chemically dependent, (Van Wormer, 1990; Cermack, 1991) enablers or co-alcoholics became known as co-dependents, thus the emergence of the concept. Since then, the term has been expanded considerably to include not only spouses and children of alcoholics, but also adults who were raised in alcoholic families, referred to as adult children of alcoholics (ACOA's). Grandchildren, relatives and co-workers were also included; basically, anyone who had significant contact with an individual who experienced an addiction. The concept also was expanded to not only include addiction to alcohol, drugs, work, sex or any other compulsive behavior such as gambling or shopping but also to include codependency as a result of exposure to a dysfunctional family system without the presence of an addiction; basically, "anyone who...grew up in an emotionally repressive family" (Lisansky Gomberg, 1989, p. 115).

Although there is no known cause of codependency, family of origin is believed to be influential in its development and perpetuation.

Family of origin refers to the family in which one is raised including parents, siblings, grandparents and close relatives. The importance of a functional/healthy family is documented extensively in the literature. (Satir, 1972; Ackerman, 1958; Strong & DeVault, 1989; Christensen, 1967; Bandura, 1964; Winnicott, 1965; Geringer-Woititz, 1983; Mellody, 1989: Lefcourt, 1982; Coopersmith, 1967; Stringer, 1971; Beane & Lipka, 1984; Phares, 1976; Bradshaw, 1988). The family, defined as "the basic unit of growth and experience" (Ackerman, 1958, p. 15) has several important functions: the provider of the necessities of life (Ackerman, 1958); the socialization of children (Parson & Bales, 1955; Ackerman, 1958; Christensen, 1967); the inoculation of values and attitudes which give children a proper fit into society (Parson & Bales, 1955); and, the development of children's identities, shaping the development of their personalities and determining their mental health (Christensen, 1967). As well, the family unit provides the opportunity to evolve a personal identity tied to family identity, the training toward integration into social roles, the acceptance of social responsibility, the patterning of sexual roles, the cultivation of learning and the support for individual creativity and initiative (Ackerman, 1958). Richardson states that the family has a tremendous impact as "the way we see ourselves, others and the world is shaped in the setting of our family of origin" (1987, p. 1)

The health of the family system is reflected in its structure, including rules and roles, identity, which involves connectedness and communication and lastly, stability. These aspects will be addressed within the context of the alcoholic family.

The Alcoholic Family

The alcoholic family is typically characterized by an undercurrent of tension and/or anxiety. Typical features include unpredictability, unreliability, denial, fear, chaos, physical, sexual, emotional or mental abuse of both spouses and/or children, authoritarianism, rigidity, instability and inconsistency in its rules, discipline, behavioral expectations and limits (Beletsis & Brown, pamphlet). Communication patterns tend to be indirect and the discussion of issues or feelings is avoided (Gravitz & Bowden, 1985; Beletsis & Brown, pamphlet). Bradshaw states that "within alcoholic families there is a denial of five basic freedoms: the freedom to perceive, think and interpret, feel, want and choose and lastly, the power to imagine" (1988, p. 39).

Structure

Central to the structure of the family system are rules and roles which serve to maintain the equilibrium of the family unit. Richardson (1987) defines rules, both spoken and unspoken, as a set of expectations about how people should conduct themselves in various settings. According to Strong and Devault (1989), there is a hierarchy of rules within every family whether functional or dysfunctional: the individual rules based on roles such as wife, mother, sister and brother; the family rules which are the combined rules of the members as a group; and, the metarules, which are abstract rules generalized from the family situation. Strong and DeVault (1989) state that in the case of secrecy around an alcohol problem, a metarule may develop in relation to any other topic that may cause a problem.

In functional family systems, rules tend to be realistic, humane and individual family members' needs, wants and feelings are taken into consideration; there is a degree of flexibility that allows for individual expression, the ability to make mistakes (Bradshaw, 1990) and the recognition of family members as unique. In comparison, the rules within an alcoholic family are inhumane, rigid and are designed to keep the family system closed. Beletsis and Brown (pamphlet) state that rules develop as a result of the emphasis on denial and the reality of the inconsistency and unpredictability of the alcoholic family. As well, the rules do not allow for individual freedom; rather they support a position of control and rigidity. According to Lord et al. (1987), "they grow out of the alcoholic's personal goals, which are to maintain his access to alcohol, avoid pain, protect his defenses, and finally deny that any of these goals exist" (p. 423). In conclusion, Satir (1972) states that "any rule that prevents family members from commenting on what is and what has been is an excellent source for developing a restricted, ignored and uncreative person, and a family situation to match" (p. 110).

Wegscheider (1981) identified seven rules that operate within alcoholic families: the dependent's use of alcohol is the most important thing in the family; that is, the use of alcohol is the family's overriding concern and many of their activities are planned around it; alcohol is not the cause of the family's difficulties; and, the alcoholic is not responsible for his/her alcohol dependency, a belief that results in inappropriate blame and feelings of guilt. As well, the status quo must be maintained at all costs, which ensures the rigidity of the family system; all family members must be enablers and must assume family roles that allow the alcohol problem to continue; no one may discuss the alcohol problem both within the family as well as outside, which ensures the isolation and closed nature of the alcoholic family and lastly, no one may express feelings. Black (1981) simplified this by compiling three basic rules which she believes operate in all alcoholic families: don't talk, don't feel and don't trust.

The first rule, don't talk, involves the silence and secrecy that surrounds alcoholism. Children are given verbal messages from their parents, usually spouses of alcoholics, about what is open for discussion. Children also observe that their parents do not address the alcohol problem and if the subject is brought up, the results are anger, arguments and violence. More importantly, there is denial, especially from the alcoholic. If the children attempt to address the problem, they may experience humilation, punishment or shame.

Also inherent within this rule is the expectation that no one discuss the family situation with anyone outside the family system. Not only are family members isolated from one another, they are also isolated within their community resulting in the continued secrecy and perpetuation of the alcohol problem. As well, if there is no opportunity to check out the problem, then the problem becomes a fact and that fact becomes the basis upon which children will base their actions and opinions (Satir, 1972).

The second rule is don't feel as feelings in an alcoholic home are perceived to be dangerous. For example, children observe that when a parent is angry, violence is the result; therefore, they equate feelings with behavior and fail to learn that the two are separate entities. Children may come to believe that their feelings are bad, wrong or something to be ashamed of. Furthermore, if a distinction is not made between the feeling and the action, then a child learns to inhibit the feeling (Satir, 1972) and finally internalizes them.

The third rule is don't trust. Because of the internalization of feelings and the restriction upon an open discussion of the family problem, children gradually believe that there is something wrong with them. Consequently, they fail to learn to trust their own perceptions and feelings, their parents, other significant people in their lives and even God when their prayers for a solution to their families' difficulties are unanswered.

The second element important in the structure of the family unit are the roles that individual members play.

According to family systems theory, family members adopt identifiable role behaviours as coping strategies (Hemfelt, 1989) or defense mechanisms (Van Wormer, 1990) when experiencing stress (Gravitz & Bowden, 1985). In functional families, roles are flexible in that family members have the freedom to experiment with different roles in an attempt to secure an identity for themselves; that is, they have more choices (Bradshaw, 1990). As well, clearly delineated roles are important for children as they determine whether they are able to identify with and internalize their present and future roles. This depends on how clearly these roles emerge from their families (Christensen, 1967). Gravitz and Bowden (1985) state that in unhealthy families the roles are so "rigid and encompassing" (p. 25) that they become a way of being and family members lose their identities within them. In fact, these roles facilitate each member's ability to reinforce the unhealthiness in other members as well as the family as a whole (Gravitz & Bowden, 1985).

Numerous roles that are enacted within the alcoholic family are addressed within the codependency literature: the responsible one, adjuster and placater (Black, 1981; Satir, 1975; Gravitz and Bowden, 1985); caretaker, people-pleaser, martyr, workaholic, perfectionist and stump (Larsen, 1986); and star, trouble-maker, clown and invisible one (Bradshaw, 1990). Wegscheider (1981) also identified the hero, scapegoat, mascot and lost child. Hemfelt (1989) states that these latter four roles occur in every family to a limited extent but that others are generated by alcoholism itself: enabler, placater, martyr, rescuer, persecutor and victim. The roles of hero, scapegoat, mascot and lost child will be addressed.

The hero, also referred to as the responsible one, star or caretaker, is usually the oldest or only child within the family. Sensing that one or both parents are unable to cope, the child experiences considerable anxiety and may attempt to resolve it by maturing at an early age and assuming responsibility for the family. This may include preparing meals, caring for younger siblings, being the confidante for one or both parents and mediating parental quarrels. This child is usually very successful, is a high achiever in school and/or sports, is well-liked and may be described as being nice and quiet. He/She attempts to bring honour and unity to the family through accomplishments and to show the community that the family is doing well.

The second role played within the alcoholic family is that of the scapegoat. He/She is typically the middle child and is often referred to as the black sheep or trouble-maker of the family. Difficulties may be experienced with drugs, alcohol, truancy, theft and attempted or actual suicide; destructive behaviours which serve to provide distraction and focus for the family. In counseling practice, this child is typically identified as the problem by the parents rather than the alcohol problem itself. In fact, this child may be one of the most sensitive members of the family and through negative behaviours may be expressing family pain (Bradshaw, 1990).

The third role played within the alcoholic family is the mascot or clown. Through the telling of jokes and funny stories, the tension in the home is alleviated. Lastly is the role of the lost or invisible child, typically the youngest member of the family. This child usually makes no demands, is quiet, tends to be a loner and disengages him/herself both emotionally and physically from the home.

It is important to note that not every child of an alcoholic is affected in the same way. Factors such as the sex of the alcoholic parent, whether one or both parents are alcoholics and the severity of the alcohol problem are determining factors. As well, the child's age when the alcohol problem becomes severe and the number of children within the family all influence the impact that alcoholism has upon the child and the role(s) that will be assumed (Beletsis & Brown, pamphlet).

Identity

According to Ackerman (1958), the family is the medium through which the identity of a person emerges. The facilitation of individual identity is, in turn, affected by the psychological identity of the family unit comprised of the individual members. That is, "the elements of joined...identity-strivings, values, actions, expectations, fears and problems of adaptation, mutually shared in or complemented by the role behaviours of members of the family group" (Ackerman, 1958, p. 84). Ackerman (1958) also states that "the more distorted the personality, the less healthy are the basic layers of joined identity with the family and the deeper the failure to differentiate an integrated separate self" (p. 19).

The family identity facilitates the division of power, sexual differentiation, child-rearing practices and "determines the manner in which elements of sameness and difference among the personalities of family members are held in a certain balance" (Ackerman, 1958, p. 84). Important contributing factors in the development of identity include connectedness and communication between family members.

Connectedness

Connectedness is defined by Covington and Beckett (1988) as "a feeling of closeness, of being an integral part of the family, of having a sense of solidarity and cohesion with the other members" (p. 29). The alcoholic family experiences a lack of healthy connectedness; rather, it is characterized by fragmentation, isolation and alienation. Ackerman (1958) states that this is a reflection of the unhealthiness of individual family members whose individual identities tend to be conflicted, fragmented and confused.

Connectedness within the alcoholic family tends to be in the form of coalitions, the most common form being triangulation. Coalitions are quite common in all families and occur because it is "difficult for any two people in a relationship to focus just on themselves and maintain a one-to-one relationship" (Richardson, 1987, p. 52). Within any family system, two close members may form a coalition against the other person and overlook their differences with each other. In fact, Richardson (1987) states that "in coalitions, the inside person is good and attractive and the outside person is bad and unattractive" (p. 62) and reality is distorted.

Relationships within the alcoholic family are a prime example of coalitions and triangulation. In the alcoholic family, secret coalitions are formed, are not openly acknowledged and are very destructive. However, they serve two important functions: to reduce anxiety caused by alcoholism; that is, to maintain the stability of the family; and, to control a third party, usually the alcoholic (Richardson, 1987). The most common coalition is between the spouse of the alcoholic and the children as the spouse relies on the children to provide support and strength in dealing with the alcoholic. Therefore, children are forced, often unknowingly, into forming an alliance with one parent in order to survive within the family system. This results in isolation, alienation and rejection of one or perhaps several family members.

The roles children assume within the family are also coalitions. In healthy families, every family member gets to play a role; however, in unhealthy families, "particular roles get attached to particular people" (Richardson, 1987, p. 67). This type of coalition is demonstrated most effectively in the scapegoat role. That is, by providing a focus for the family, the parents are able to ignore their difficulties and focus on the problems of the acting-out child.

Communication

Communication, both verbal and non-verbal, is the foundation of both a healthy marriage and a healthy family and is essential in arriving at satisfactory relationships (Strong & DeVault, 1989; Christensen, 1967). Satir (1972) states that communication is the largest single factor in determining what kinds of relationships one makes and what happens to an individual in the world. Ashkam (1976) states that it is critical for a balance between individual identity and the stability of the marriage and family system.

In a healthy family system, communication is direct and clear. Feedback is provided to all family members resulting in high levels of intimacy and trust. Communication also involves mutual acceptance of all family members, a sense of liking one another and an expression of liking in both words and actions (Ashkam, 1976). In the alcoholic family, communication tends to be restricted to superficial subjects and is ineffective in resolving difficulties. As well, mixed messages such as "do as I say, not as I do" (Covington & Beckett, 1988, p. 20) are common. Communication tends to be blocked by blame, generalization, denial, secrecy, anger, aggression and a lack of self-awareness as a result of a lack of feedback. Consequently, family members feel isolated from one another, trust is low and there is little intimacy. As well, in order to maintain the stability of the family unit, unacceptable feelings including anger, hurt or sadness, are suppressed.

Stability

The stability of the family refers to the equilibrium of the family unit and the maintenance of the sameness or continuity of family members over time. It also includes the continuity of the identity of the family, the control and management of conflict, the capacity to deal with change, to learn new ideas and to fill new life roles as an adaptation to the changing family. (Ackerman, 1958). Six important strengths that help family members to survive, learn and thrive have been identified (Covington & Beckett, 1988; Stinette & Defrain, 1985):

1. Commitment to the family, making the family a priority.

2. Emotional/spiritual wellness, allowing trust and the giving and receiving of love.
3. Open communication, with consistent verbal and nonverbal responses.
4. Appreciation and recognition of the positive aspects of otherness.
5. Meaningful time spent together as a family.
6. Ability to deal with conflict and crisis.

In an alcoholic family, stability is not maintained given the unpredictable nature of the alcoholic and the reactions of the family members. As a result "exaggerated concern with issues of control and discipline" (Ackerman, 1958, p. 118) emerge causing the family system to become rigid and closed.

In a closed family system, family rules are covert, rigid and out-dated. Family members are required to change their needs to conform to the family rules and communication is indirect, unclear and unspecific. As well, family members are restricted in their ability to comment about what is going on (Strong & DeVault, 1989; Satir, 1988; Satir, 1972). This leads to the development of defenses such as scapegoating, projection and isolation in order to ensure that the family system remains stable.

A family's health depends not so much on what challenges it faces, but on the way in which it responds to the challenges that all families face. The alcoholic family is characterized by conflict within individual family members, between family members and with the community. The alcoholic family has few resources to identify, manage or resolve conflict. Inevitably, the failure to resolve conflict through effective problem solving and decision making results in the breakdown of the family unit, denial, emotional illness in both individual members and the family as a whole and the increased rigidity of family dynamics. As well, emotional growth is stifled and family members tend to act out in order to externalize the conflict experienced. The consequence is that the family system becomes closed so that the family is prevented from learning new methods of conflict resolution and to move into new life roles with the changing nature of the family.

Given that the family system is so critical in the emotional development of its members, each stage of a child's development can be significantly affected by the dysfunction of the family unit. The following section will address the development of codependency within the family system throughout infancy, childhood and adolescence. Following this, particular emphasis will be placed on the development of self esteem and locus of control.

Stages of Development

There are numerous theories of child development cited in the literature. The developmental model advocated within the codependency literature will be presented.

Infancy

From the moment of birth, infants are completely dependent upon their parents for survival. Mellody (1989) describes infants as valuable, vulnerable, imperfect, dependent and immature. Bradshaw (1990) states that infants are completely trusting, powerless and vulnerable making them particularly sensitive to abuse. He refers to the infancy stage as a healthy stage of codependency during which parents are responsible for meeting their infant's developmental dependency needs.

Infants initially interact with their environment directly through their senses: sight, touch, hear and smell (Crain, 1980; Schachtel, 1959; Rousseau, 1762). Bradshaw (1990) refers to this as a time of sensory acuity. Infants are unaware that others exist separately as they have not developed object permanence (Crain, 1980; Piaget, 1936). Freud describes infants as objectless as "there is no conception of people or things existing in their own right" (Crain, 1980, p. 125), and refers to this as "primary narcissism" (Crain, 1980, p. 125).

The parent/infant bond is the most critical aspect of this stage of development as the quality of this relationship "transmits from parent to infant the beginning of the ability to relate positively to others" (Stringer, 1971, p. 24; Bowlby, 1969). Lewis and Rosenblum (1979) demonstrated that attachment to the father is also important for subsequent development in that the establishment of a positive relationship with someone other than the mother makes it easier for infants to establish trusting relationships with others.

Infants learn about their importance from the reactions of their parents through mirroring, smiling, touching, responding and talking. Bradshaw (1988) states that babies first learn to value themselves by the mirroring received from others and that "their core identities come first from the mirroring eyes of their primary caretakers" (p. 29). Babies require unconditional positive regard to be mirrored within the mother's face in order to feel completely loved and accepted. This is a necessary prerequisite to developing a healthy sense of self.

The second lesson of worth is smiling through which infants learn that they are delightful. In fact, smiling is one of the most important and powerful attachment behaviours as "it maintains the proximity of the caretaker...[and serves as]... a releaser which promotes loving and caring interaction - behavior which increases the baby's chance for health and survival" (Crain, 1980, p. 45; Bowlby, 1969, p. 246).

"Touch is a life-giving force for infants" (Strong & DeVault, 1989, p. 370) and teaches infants that they are safe. Montagu (1976) has demonstrated that if infants are not touched, they may fail to thrive and may even die.

Parent's responsiveness teaches infants that they are effective in getting their needs met and are important. Bell and Ainsworth (1972) demonstrated that when mother's consistently and promptly responded to their babies' cries, the babies cried little and were quite independent by age one. As well, when mothers consistently ignored their babies' cries, the babies tended to become isolated, overly attached and appeared helpless when left alone (Ainsworth, 1967; 1973). Winnicott (1965) indicates that it is well-cared for babies who quickly establish themselves as persons, whereas babies who receive inadequate or pathological ego support tend to be alike in patterns of behavior in that they are restless, suspicious, apathetic, inhibited and compliant.

Numerous studies have demonstrated the importance of parental verbal stimulation and responsiveness to their infant's attempts to talk in the development of cognitive abilities, emotional growth and language (Lewis & Rosenblum, 1979; Smith, Adamson & Bakeman, 1986; Olsen, Bates & Bayles, 1984). Clarke-Stewart and Friedman (1987) demonstrated that unresponsive parents are critical, offer no reinforcement or models, do not accept their infant's language as meaningful and that their infants tend to lag behind in their language development as they mature.

One of the most critical elements of this stage is the development of trust whereby babies learn that the world is a safe place and that they can get their needs met. Given that babies' primary interactions are with their parents, Erikson states that it is essential that babies sense consistency, predictability and reliability in their parent's actions as well as in the environment.

Without this, babies cannot develop trust and quit believing that they can depend on others (Crain, 1980). Consistent care is also important for the development of one essential ego-function; that of the ability to postpone gratification (Crain, 1980, Benedek, 1938).

The development of trust also depends on the parents' confidence in their ability as parents. Sullivan reports that in the first months of life, infants have a special kind of physical empathy with their mothers, or primary caregivers, in that they automatically feel the caregivers' state of tension (Schachtel, 1959). Whitfield (1987) indicates that if babies sense that the mother is needy, they will learn to detect her specific needs, and will begin to provide them for her. Therefore, it is important that caregivers have a sense of confidence in themselves in order to enable babies to feel that it is good and reassuring to be close to other people. Mellody (1989) states that the development of trust requires two elements: enough experience of being well-loved to stimulate a desire for more and secondly, enough exposure to delay and disappointment to encourage trust as a way to postpone gratification. This results in babies' heightened sensitivity to parents' moods.

The alcoholic home does not provide consistency and/or predictability and given that the environment is characterized by tension and anxiety, it is likely that infants will develop difficulties with trusting themselves, trusting others and learning to trust discerningly. Bowlby (1969) has demonstrated that failure to develop a solid attachment in early life results in the inability to form loving, lasting relationships with other people throughout one's life. In fact, difficulty with trust is a main problem experienced by many individuals raised within an alcoholic environment (Mellody, 1989; Beattie, 1987; Bradshaw, 1990; Hemfelt, 1989; Friel & Friel, 1990).

Bradshaw (1990) states that if babies do not receive unconditional positive regard expressed through mirroring, touching and echoing, they will experience this as abandonment; therefore, they will reject those parts of themselves that are not mirrored back and develop a fragmented sense of self. As well, babies who are not comforted, held, spoken to, rocked or loved learn helplessness and may suffer from stroke deprivation; that is, when their cries do not bring relief, they learn that they and their needs are unimportant. Whitfield (1987) states that if infants do not receive touch, mirroring, echoing and security, their physical, mental, emotional and spiritual growth will be stunted.

Bradshaw (1990) states that if infancy needs are not satisfied, the underpinnings for the emergence of unhealthy codependency will be established and may result in the following codependent characteristics:

1. Drinking or eating disorders - the satisfaction of unmet oral gratification needs;
2. Mistrust of people and the need to control others in order to feel safe and secure;
3. A deep fear of abandonment; an inability to let go; overly attached;
4. A continuous need for admiration or unconditional positive regard from others;
5. Being out of touch with the physical body: unaware of exhaustion, hunger and/or stress, until an illness develops;
6. Gullible behavior; failure to learn to trust discerningly.

Childhood

Childhood is comprised of the toddler stage, nine months to three years, the preschool stage, three to five years, and the school stage, six to 11 years (Crain, 1980). The toddler emerges with a change in the infant's awareness;

that is, the realization that he/she exists separately from others. This begins a process of separation referred to by Erikson as autonomy (Crain, 1980). Bradshaw (1990) refers to this stage of development as counterdependency as evidenced by the frequent use of the word no, temper tantrums and anger. Winnicott (1965) refers to this stage as a struggle against security as "the individual small child now pounces on every new opportunity for free expression and for impulsive action" (p. 32).

The toddler stage is comprised of significant developmental changes including physical development such as crawling, walking and talking. According to Piaget, symbolic thought is the major new cognitive activity (Clarke-Stewart & Friedman, 1987). This development allows for the use of symbols which in turn allows toddlers to draw, pretend, play and to use language meaningfully. Throughout this stage, the toddler begins to explore the environment and needs to exercise free will and freedom to make choices. It becomes the parents' responsibility to provide attention, time, commitment, direction and good modelling as well as a safe environment for exploration as the toddler requires protection from danger including structure and limits. Winnicott (1965) indicates that in order to facilitate healthy emotional development, toddlers need their parents to be in control. Discipline must be provided by parents who can be both loved and hated, defied and depended on. Piaget refers to this as object constancy; that is, learning that people are both good and bad (Crain, 1980). Through structure, toddlers learn a healthy sense of shame and doubt as they develop an awareness of societal expectations and pressures. As well, they will develop self-restriction and internalize social prohibitions (Crain, 1980).

Bradshaw (1990) states that if the needs of the toddler are not met, toddlers will develop the following codependent characteristics:

1. Trouble knowing what they want. This will emerge as a result of not having had the opportunity to figure it out for themselves;
2. Fear of trying new experiences as a result of either a lack of exploration or perhaps an unsafe environment in which they were injured as a result of exploring;
3. Feeling that they have to follow others suggestions; failure to master the initiative stage of development
4. Frequent conflicts with authority or the avoidance of conflict; a failure to learn how

to resolve conflict, a lack of modelling, or parents inability to set limits and structure;

5. Fear of anger; learning that anger is not accepted in the family or the witnessing of family violence;
6. Will avoid saying no directly but instead will lie or get sick.

The establishment of a healthy sexual identity is important throughout childhood (Strong & DeVault, 1989). Starting as early as age three, children develop curiosity about their genitals as well as the genitals of others (Crain, 1980). They begin to imagine themselves as adults in adult roles and require modelling for what it means to be an adult male or female and how to be in a relationship. However, if children are made to feel bad, wrong or ashamed for experimenting with their sexuality, they will develop low self-esteem and will experience difficulty with emotion and sexuality later in life. Strong and DeVault (1989) state that children will learn to devalue their sexuality if they are told that they are bad when they exhibit sexual behavior and more importantly when they observe the "concealed nature of [their parents'] communication about it" (p. 316; Lerner, 1975; Pogrebin, 1983). If their curiosity is satisfied, they will feel more comfortable with their bodies as adults and will develop higher self-esteem which will make them less vulnerable to manipulation and victimization (Pogrebin, 1983; Strong & Devault, 1989). Erikson states that it is during the preschool years, that the child experiences the stage of initiative versus guilt. Bradshaw (1990) refers to this stage as independence. Between the ages of three and six, preschool children begin to create, invent and try to set and achieve goals for themselves. Erikson states that "three to six year old children are ready to learn quickly and avidly, and are more willing...than at any other time...to find ways to channel their ambitions into socially useful pursuits" (Crain, 1980, p. 153; Erikson, 1950, p. 258).

The final stage of childhood development experienced by school-aged children is that of interdependence (Bradshaw, 1990) and industry versus inferiority. (Crain, 1980). Cognitive abilities progress to concrete thinking allowing children to use logic and to appreciate jokes (Clarke-Stewart & Friedman, 1987). According to Erikson, this is a critical time for ego growth as "children master important cognitive and social skills" (Crain, 1980, p. 154). School, peers and family are all influential during this stage as children learn to do meaningful work such as reading and arithmetic and "are developing the ego strengths of steady attention and persevering diligence" (Erikson, 1950, p. 259). However, if children do not perform well in school, are taunted or teased, have poor teachers who are unable to encourage learning, or have abusive or otherwise dysfunctional home environments, children will develop a sense of inadequacy and inferiority. Sears (1970) reported that sixth grade children whose parents displayed warmth and affection were more often found to have high self-esteem. Clarke-Stewart and Friedman (1987) state that "parents are of central importance, and whether the family is happy or not profoundly influences how children feel about the world and their place within it" (p. 484).

Bradshaw (1990) states that if the needs of the school-aged child are not met, the following codependent qualities will emerge:

1. Feeling uncomfortable in social situations;
2. Being excessively competitive; failure to learn cooperation;
3. Giving in or needing to have everything their own way;
4. Developing an internal fear of making mistakes;
5. Lacking basic life skills;
6. Feeling ugly, inferior and social shame.

Bradshaw (1990) indicates that if the developmental needs are not met at this stage, a disorder will develop and will result in the child feeling as if achievement is all that matters and will become a "human-doing" (Bradshaw, 1990) instead of a human-being or will drop out as a result of excessive shame.

Bradshaw (1988) also states that experiences in childhood such as violence, abuse, neglect, abandonment or trauma like that experienced in the alcoholic family, will result in the development of neurosis. This results from the internalization of shame, doubt and guilt and the development of what Bradshaw (1988) refers to as toxic shame. He also states that any human emotion can become internalized and "when internalized, an emotion stops functioning in the manner of an emotion and becomes a characterological style...the core of the person's identity" (pp. 10-11). Through identification with shame-based models, children learn that they are flawed and defective as human beings. Consequently, children learn that they are not accepted for who they are; rather, they are given rules about who and what they should be. As well, they are not permitted to separate from parents and always have to measure up to the parents' expectations. A prime reason for this lack of separation is that the children are required by one or both parents to fulfil unmet needs in the marital relationship. Bradshaw (1990) refers to this as the spousification of children. Bradshaw (1990), Lewis and Rosenblum (1979); Epstein et al.(1982); Lewis et al. (1976) state that a healthy marriage is vital to any healthy family. If mom is not the most important person to dad, and vice versa, children become sucked into the intimacy dysfunction, lose their identities and realities and develop confusion about their sexual identities. It is important to note that children are basically egocentric; that they feel responsible for the problems in the family and the marriage. If children do become enmeshed in their parent's relationship, they may experience the following:

1. Trouble identifying their own feelings;
2. Interpersonal communication difficulties as a result of a lack of modelling of open communication between the parents;
3. Act on assumptions; do not check out their feelings; trouble expressing their feelings;
4. Feel responsible for the feelings of others;
5. Take care of the family's or one parent's unhappiness.

In summary, Kagan (1976) states that children need to feel valued by parents and a few special adults such as relatives or teachers. They also need to develop autonomy in their attitudes and behaviours, talents that can be used in society, and be able to love and be loved.

Adolescence

Adolescence is a universal stage experienced by individuals between the ages of eleven and eighteen and is defined as the"...transition period between childhood and adulthood during which the individual is weaned from childish habits and prepared for taking on adult responsibilities" (Mitchell, 1975, p. 4). Ackerman (1958) states that adolescence is manifested by insecurity, instability of mood and action, sexual drives, rebelliousness, fear of inadequacy and failure and an aspiration to succeed in some field of human achievement. Adolescence is a time of turmoil, coping, turbulence, conflict, storm and stress and personal discovery (Ackerman, 1958; Strong & DeVault, 1989; Mitchell, 1975; Clarke-Stewart & Friedman, 1987; Hall, 1904; Freud, 1972). The needs of adolescents are many: identity, self-importance, a sense of meaning, peer approval, conformity, acceptance, independence, security, order and certainty, the need to learn, the freedom to make and exercise choices and sexual expression (Hollingworth, 1928, Mitchell, 1975, Fenigstein et al., 1975; Erikson, 1959; Erikson, 1968; Cantril, 1964; Havighurst, 1953).

Adolescents experience profound and rapid changes including physical developments, psycho-social changes and cognitive changes. One of the hallmarks of adolescence is the onset of puberty with the accompanying development of primary and secondary sexual characteristics, the sexual and aggressive drives, increases in height and weight and changes in hormonal secretions (Crain, 1980). The psychological counterparts to these physical changes include moodiness and self-consciousness.

Adolescents also experience psycho-social changes that stem from these physical changes. These include sexual, parental and independence conflicts. With the emergence of the sex drive, adolescents must deal with their sexuality. This involves learning gender and sex roles; that is, what it is to be male or female and how to behave in sexual situations, the need to satisfy sexual drives as well as meet societal expectations about appropriate sexual behavior and to develop a personal conscience about appropriate sexual attitude and behavior that one wishes to adopt. As well, the adolescent is also faced with dating, finding suitable partners and learning to be intimate with members of the opposite sex.

Parent/teen conflict is a universal characteristic of adolescence. There are several contributing factors: the need to reshape relationships with parents, the conflict between the adolescent's desire for freedom and the parent's desire for limits and control and the adolescent's need to determine their own beliefs, values, rules and opinions which means a temporary rejection of those held by parents. Also inherent in parent/teen conflict is the struggle for independence. That is, although adolescents require structure, security and protection from their parents, they also rebel against this in order to create a place for themselves in society that is independent of their family. Typically they do this by identifying with peer groups.

Peers are an important source of learning for teenagers, particulary about sex (Gebhard, 1977). Strong and DeVault (1989) indicate that an adolescent's perception of peer's sexual behavior may be the single most important factor in determining his/her non-sexual behavior.

The third significant change that adolescents experience is in their cognitive abilities as they move from concrete to formal operations which allows them to think about possibilities, to reason abstractly and to speculate (Crain, 1980; Piaget, 1955; Miller, Kessel & Flavell, 1970; Clarke-Stewart & Friedman, 1987). Piaget indicates that formal operations have a significant role in the adolescents social life as it allows them to think about their futures (Inhelder & Piaget, 1955). Consequently, adolescents are able to reflect on themselves and become introspective and self-analytical. Mitchell (1975) states that "at no time during the life cycle is a greater portion of psychic energy consumed in self-analysis than during adolescence" (p. 47).

As a result of formal operational thinking (Elkind, 1967) as well as advances in social understanding (Clarke-Stewart & Friedman, 1987), adolescents become very egocentric; this is what makes them think that they are more important, unique and unusual than they really are. Out of this emerges self-consciousness which is a reflection of heightened concern with an imaginary audience. Elkind (1967) states that because adolescents fail to make a distinction between their own thoughts and the thoughts of others, they assume that other people are as preoccupied with their thoughts and behaviours as they are. Mitchell (1975) refers to this as "other-centredness" (p. 129).

The search for and establishment of an identity is paramount and universal in adolescence (Mitchell, 1975; Ackerman, 1958; Crain, 1980) identity being defined as "...how a person thinks of and defines himself, taking into consideration his own expectations of himself and the roles society assumes he will carry out" (Mitchell, 1975, p. 52). Adolescence is a time when teens experience considerable confusion about who they are and ask questions such as "who am I, what is my goal or purpose and what is the meaning of life?" (Mitchell, 1975, p. 17). Erikson refers to adolescence as a time of identity versus role confusion (Crain, 1980). He states that given the changes experienced by adolescents including physical changes, psycho-social conflicts, and shifts in emotional, social, sexual and intellectual behavior, adolescents need to establish a new identity.

Adolescents also develop their identities as a result of accomplishments and therefore need to have a sense of self-importance; a sense that what they do makes a difference. Self-importance is essential as it provides confidence to face new situations, a reserve of psychological strength in order to cope with stress and anxiety and a lack of desire to prove themselves to other teens (Mitchell, 1975).

Mitchell (1975) states that adolescents in our culture experience an "involvement crisis" (p. 9) as they are prevented from participating in the important events of society. However, the adolescent holds strong needs for status, acceptance and independence which are satisfied only when he is able to try different roles. In fact, adulthood can not exist in any personally meaningful way without the freedom to sample identities during the protection period of adolescence (Mitchell, 1975). Strong and DeVault (1989) state that the transformation of personal identity and the relation of this to parental family identity is a critical phenomenon in adolescence. Those who fail to achieve identity appear to come from more rejecting and detached families; often the father is absent or the parents are intrusive and possessive (Matteson, 1977).

If identity is not achieved, the adolescent will experience significant difficulties including:

1. Incapacity for personal intimacy; isolation and intimacy with unavailable partners;
2. Diffusion of time perspective; a disbelief that time will change their situation;
3. Diffusion of industry; inability to concentrate;
4. The choice of a negative identity; disdain of

family.

Mitchell (1975) also states that if adolescents are unable to make a difference or establish an identity the results can include drug use, hostility, theft, vandalism, alienation and apathy. As well, they can develop the growth disorder of neurosis which prompts the use of denial and projection, making interpersonal relations difficult.

The Development of Self-Esteem

Numerous definitions have been documented with regard to self-esteem. Coopersmith (1967) defines self-esteem as the evaluation which an individual makes and maintains with regard to her/himself; "it expresses an attitude of approval or disapproval and indicates the extent to which the individual believes himself to be capable, significant, successful and worthy" (pp. 4-5). Allport (1967) describes self-esteem as simply a sense of self; Maher (1966) states that it is a cluster of specialized attitudes towards one's own person and towards others; Wylie (1961) indicates that self-esteem is the congruency between the self and the ideal self.

According to Friel and Friel (1990), children growing up in alcoholic families develop a split between their private and public selves as a result of abandoning their true selves for survival. That is, "to secure a place within the dysfunctional family, children have to surrender their own self-worth and accept a degraded role" (Beane & Lipka, 1986, p. 19). As a result, codependents tend to experience low self-esteem, often experience a lack of self and tend to develop "other-esteem" (Mellody, 1989, p. 8) which includes how they look, who they know, the degrees they have earned and what kind of job they have. The problem is that the source of other-esteem is outside the self and thus vulnerable to changes beyond one's control. This significantly affects their abilities, achievements, careers and most importantly, their relationships with others. According to Coopersmith (1967), those individuals with low self-esteem tend to feel inadequate and unworthy, see themselves as helpless and inferior, incapable of improving their situation and lacking the inner resources to tolerate stress. As well, those with low self-esteem tend to exhibit higher levels of anxiety, lower in the affect they express and are likely to exhibit more frequently psychosomatic symptoms and feelings of depression than someone with high self-esteem (Coopersmith, 1967).

Self-perceptions depend partly on the developmental characteristics of particular stages of growth. (Beane & Lipka, 1986). The development of self esteem will be addressed within the developmental stages of infancy, childhood and adolescence.

Infancy

Infants are not born with a self-concept; that is, they do not yet know who or what they are. Kelly (1962) and Mead (1934) state that the self develops almost entirely as a result of interaction with others. Therefore, feedback from parents is critical and the development of clear and positive self-images in children depends on the kind of home environments or climates provided by the parents. That is, "infants absorb the esteem their parents have for them, and this internalized esteem from parents becomes the basis of self-esteem" (Mellody, 1989, p. 62). Stringer (1971) states that "an infant's self-esteem emerges as the child absorbs into his beginning sense of self the love that others, particularly his parents, show toward him (p. 119).

Childhood

McKay and Fanning (1987) state that "studies of young children show clearly that parents' style of childrearing during the first three or four years determines the amount of self-esteem that a child starts with (p. 208). Low self-esteem usually has roots in early experiences of abuse, shame or abandonment (McKay & Fanning, 1987; Mellody, 1989); in fact, "the most significant contributor to an early feeling of wrongness is the sense that one has somehow been abandoned" (McKay & Fanning, 1987, p. 208). Coopersmith (1967) states that an environment characterized by parental warmth, respectful treatment and clearly defined limits will result in the development of positive self-esteem. McKay and Fanning (1987) have identified five main factors that determine low self-esteem:

1. The degree to which issues of taste, personal needs, safety or good judgment were mislabelled as moral imperatives. To illustrate, children may be made to feel wrong for being noisy, having low grades, having sexual feelings and/or spending time with friends.
2. The degree to which parents failed to differentiate between behavior and identity. That is, children fail to learn the difference between what they do and who they are; therefore, if a mistake is made, children learn that they are wrong or bad rather than

learning that the behavior was wrong but that they are still lovable.

3. The frequency of forbidding gestures; the frequency of negative messages. This includes being labelled as stupid, lazy or selfish.
4. The consistency of the forbidding gestures with the conclusion being that it is not what children do, it is what they are. If family rules are inconsistent, children know they have done something wrong, but "as they can never get the rules straight, they have no idea what" (p. 19). This results in feelings of guilt and shame.
5. The frequency with which forbidding gestures were tied to parental anger/withdrawal.

Children have certain needs that need to be met in order for the development of healthy self-esteem. These needs include feeling safe, secure, unafraid, effective in getting their needs met and being accepted by parents and significant others (McKay & Fanning, 1987).

In order for children to develop healthy self-esteem, they need to successfully master the developmental stages of autonomy, initiative and industry as well as establish a sexual identity. It is also essential that parents discourage their children's dependence if children are to move out into the world successfully. For example, if a mother is unable to do this for her own emotional reasons, her children may develop serious emotional difficulties in an attempt to protect the mother from feeling hurt. This may include developing school phobia (Strong & Devault, 1989). It is vital at this stage that children learn that they can be separate individuals with thoughts and ideas of their own, and still be lovable. As well, they need to know that they can be angry with their parents and that their parents will still be there for them (Bradshaw, 1990). Low self-esteem in children results in feelings of powerlessness, a poor ability to cope, low tolerance for differences and difficulties, inability to accept responsibility and impaired emotional responsiveness (Strong & Devault, 1989. pp. 322-323). Clemes and Bean (1983) describe four conditions necessary for developing and maintaining high self-esteem in children:

1. A sense of connectedness - this includes both being an important part of a family and feeling connected to their bodies;
2. A sense of uniqueness - a feeling of specialness that is supported and approved by others;
3. A sense of power - the feeling of having the

capacity to influence others, solve problems, complete tasks, make their own decisions and satisfy their own needs;

4. Modelling. This helps children to establish values, goals and clarify their own standards. It is important that parents have high self-esteem so they can accept their children for who they are, enforce limits and respect their children's individuality.

With respect to sexuality, high self-esteem will result if the child's body is respected and accepted, if the child is not punished or humiliated for seeing a parent naked or if the child's needs for privacy are respected (Strong & DeVault, 1989, p. 317).

Adolescence

With respect to self-esteem in adolescents, teenagers still require love, affection and support from their families; in fact, family support is crucial for the development and maintenance of self-esteem during this stage of development (Hoelter & Harper, 1987; Winch & Gordon, 1974). Matteson (1974) demonstrated that adolescent self-esteem is directly correlated with communication with parents. That is, adolescents with low self-esteem viewed communication with their parents as less facilitative that did those adolescents with high self-esteem. Furthermore, parents of low self-esteem adolescents perceived their communication with their spouses as less facilitative and rated their marriages as less satisfying. Rosenberg (1963) states that high self-esteem in adolescents is associated with positive perceptions of parents as well as the parent's interest in the adolescent's welfare including interest in friends, grades and including the adolescent in dinner conversations. Clarke-Stewart and Friedman (1987) state that adolescents with too much or too little experience in the areas of family cohesion, communication and structure are likely to be placed at risk in their intellectual or social development.

Of even greater importance are needs for belonging, recognition, affiliation, acceptance, popularity and membership (Mitchell, 1975) which are dependent upon group interaction and the peer group. Mitchell (1975) states that "adolescent self-esteem is primarily gratified when outsiders indicate to the person that he is respected, thought well of, admired or held in high regard"(p. 151). Adolescents are especially concerned with real or imagined injury to their self-esteem as they are extraordinarily sensitive about their concept of self (Elkind, 1970). As well, because their image is in such a state of flux, they are especially vulnerable to other person's judgments and the issue of being approved or disapproved of assumes critical importance (Ackerman, 1958).

Mitchell (1975) states that the following are necessary for the healthy development of the adolescent: self-reliance, self-priority, self-discipline and self-actualization; however, the following cannot be achieved without the fulfilment of the basic needs of love, belonging and esteem (Maslow, 1970).

Locus of Control

Locus of control is important to review as "it constitutes a personality dimension that can be quantified... [and used]... to predict human social behavior" (Phares, 1976, p. 19). Locus of control is defined as "the sense one has of one's power in life experiences" (Beane & Lipka, 1986, p. 14;), and "a generalized expectancy for internal as opposed to external control of reinforcements" (Lefcourt, 1982, p. 33). This perceived control ranges on a continuum from internal to external. Internal locus of control is a belief that events are a consequence of one's own actions and therefore under personal control. Hersch & Scheibe

(1967) indicate that internals describe themselves as more active, striving, achieving, powerful, independent and effective and seemed "to enjoy a greater potential for power" (p. 71).

An external locus of control is a belief that events, situations or people outside of oneself are responsible for direction, strength or happiness and are unrelated to one's behavior. Seeman (1959; 1967) describes externality as powerlessness or alienation and states that those individuals who are high in externality tend to manipulate or coerce others due to a lack of confidence in their own abilities. Hersch and Scheibe (1967) found that externals are more maladjusted, lower on defensiveness, achievement, endurance and order but higher on succorance and abasement (Phares, 1976). This external sense of control eventually results in a feeling of helplessness and "a perceived inability to effect one's fate meaningful, resulting further in immature and poor coping behavior" (Lefcourt, 1982, pp. 25-26) as well as chronic anxiety due to high expectancies for punishment (Hauntras & Schart, 1970; Levenson, 1974; Nelson & Phares, 1971).

Locus of control is influenced by the environment, particularly by those people who are perceived as most significant (Beane & Lipka, 1986). Internals typically come from a family environment that is warm, supportive, nurturing, with respectful treatment and clearly defined limits (Coopersmith, 1967) and that allows for self-direction and independence, a strong correlate of locus of control (Lefcourt, 1982).

In comparison, an unstable home environment is critical in the development of an external locus of control. External referenting is characteristic of a critical, rejecting, controlled and inconsistent family environment (Davis & Phares, 1969). Lefcourt (1982) states that a severely punishing environment can create a sense of fatalism or externality which results in infantile and regressive behavior.

Given the nature of the alcoholic family, children of alcoholics tend to develop an external locus of control. This perception usually manifests itself as latching onto whatever is perceived to provide peace of mind and a sense of feeling complete, finding themselves and remaining in abusive or otherwise dysfunctional relationships out of a desperate need for love and approval, needing to be liked and included so intensely that these needs take precedence over judgment and failing to stand up for their rights within a relationship because they are terrified of abandonment.

As with self-esteem, locus of control changes with developmental stages. Penk (1969) has demonstrated that there is a positive correlation between chronological age and internal locus of control; that is, locus of control becomes increasingly internal with chronological age as a result of growth in the capacity to care for oneself, independence, an ability to influence their surroundings (Phares, 1976) the development of vocabulary and usage of language. Locus of control will be examined within the context of three developmental stages, infancy, childhood and adolescence.

Infancy

In infancy, babies are helpless, powerless and depend entirely on those around them for their survival. Piaget claims that "infants cannot tell the difference between events that they cause or control and those that they do not" (Crain, 1980. p. 209). Lefcourt (1982) reports that a high incidence of stressful life events occurring in early years are associated with external locus of control scores.

Childhood

Gardner (1971) states that exposure to traumatic, incapacitating events during early childhood interferes with subsequent reality testing. This aspect of locus of control is influential in the development of denial, a characteristic of codependency. That is, when children are unable to trust their perceptions and feelings and fail to develop the skills required to test reality, they develop difficulty seeing things as they really are, frequently develop a fantasy life and may engage in compulsive or addictive behaviours in order to avoid dealing with reality as they get older. Chance, (1965) Katkovsky, Gandall and Good (1967) state:

> children's beliefs in internal control of reinforcement are related to the degree to which their parents are protective, nurturant, approving and non-rejecting...[and that]...the maintenance of supportive, positive relationships rather than a relationship characterized by punishment, rejection and criticism are more likely to foster internal control. (p. 132)

Crandall (1973) indicates that warmth and support are necessary for the assumption of personal responsibility during childhood; however, the development of an internal locus of control is best facilitated by some degree of maternal coolness, criticality and stress so that children are not allowed to rely on overly indulgent, affective relationships with mother but forced to learn objective cause and effect contingencies, adjust to them and recognize their own responsibilities in causing these outcomes. Lefcourt (1982) also states that parents who allow their children to develop with self-respect by offering choices and encouraging autonomy, will have children who develop an internal locus of control. Russell (1989) states that mothers of internals are more likely to have pushed their children toward independence, less often rewarded dependency, and displayed less intense involvement and contact with them. Rotter (1966) states that the degree of consistency of discipline and treatment by the parents is a strong predictor. That is, externals reported their parents as being more inconsistent in their discipline more often than did internals (Phares, 1976).

Adolescence

Adolescence is a period of questioning why. Adolescents who attribute achievement to their own ability or effort are more likely to feel sure of their ability to achieve. Clarke-Stewart and Friedman (1987) state that internals do well in reading, math and language, spend more time on homework, try longer to solve problems and get higher grades (Crandall, Katkovsky & Crandall, 1965; Franklin, 1963). As well, they tend to move on to tasks that they know they can succeed in after they have failed (Dweck & Licht, 1980). Butterfield (1964) states that internal adolescents tend to react to frustration in a constructive manner and with less self-blame. However, those adolescents who exhibit an external locus of control are likely to get along poorly with teachers and attribute more negative qualities to both their teachers and themselves (Bryant, 1974). As well, they tend to dwell on their failures and the reasons for them. Brissett and Nowicki (1973) state that they are more intropunitive.

Locus of Control and Self-Esteem

Research concerning the relationship between locus of control and self-esteem has demonstrated that "women with higher self-esteem tend to be more internally oriented" (Ryckman & Sherman, 1973, p. 1106).

Conclusion

Bradshaw (1990) defines codependency as a disease of the developing self. Human development is characterized by specific stages each of which possesses its own unique developments in terms of physical, emotional and mental growth. Mastery of the tasks within each stage must be successful in order for the individual to develop into a healthy/functional person. Of particular importance is the development of high self-esteem and an internal locus of control.

The onus rests upon the family, especially the parents, as it is their responsibility to ensure the healthy development of all family members. A healthy family environment, demonstrated through a flexible structure in terms of rules and roles and a solid and secure identity and stability ensured through cohesiveness and open communication, will facilitate the development of a healthy individual who will likely possess a high level of self-esteem and an internal locus of control.

The alcoholic family is a prime illustration of a dysfunctional family system that is characterized by rigidity in its rules and roles, a fragmented identity and a lack of stability, typically demonstrated through triangulation and ineffective communication. Children of alcoholic families experience difficulty in successfully mastering the tasks required within each developmental stage as the family environment does not facilitate this. Consequently, children learn maladaptive behaviours, develop low-self-esteem and an external locus of control both as a result of the family system as well as modelling received from their parents. Learning theorists state that perception always involves the past and that the interpretation one makes of his present perceptions permits him/her to predict the future, mostly on the basis of past experience. "It follows then, that one's initial experiences in infancy and childhood must have an effect on later personality organization" (Christensen, 1967, p. 745).

More importantly, the roles children assume within alcoholic families become internalized; that is, they become the childrens' identity, resulting in the failure to develop an authentic self. Instead, a codependent self develops, its severity determined by the degree to which children are unable to meet the developmental tasks of each stage.

Finally, although codependency is a new term in the alcoholic field, it appears to address the failure of achieving emotional maturity characterized by high self-esteem and an internal locus of control as a result of growing up in a dysfunctional family environment. Subsequently, individuals who fail to master the tasks of each developmental stage will experience considerable difficulty in their adult years. Recovery from codependency should utilize a life skills approach, whereby adults are given an opportunity to return to certain developmental stages and master those tasks that their environment did not allow them to master while in the infant, childhood or adolescent years. Without recovery, dysfunctional patterns and behaviours will be transmitted from one generation to the next ensuring the perpetuation of codependency as well as the problem of addiction.

CHAPTER III

Method and Procedure

The purpose of this section is to describe the sampling strategy, the sample selected for the study, the method of data collection, instruments used including scoring procedures, reliability and validity and the methods of analysis used. Approval for this research was granted by the Ethics Committee of the Department of Educational Psychology. Four questions were addressed:

1) do codependent individuals identify with low self-esteem?;
2) do codependent individuals identify with an external locus of control?:
3) will there be a significant relationship between external locus of control, low self-esteem and codependency?;
4) will there will be a significant relationship between the I/E Scale and the ICI both of which are measures of locus of control?.

Subjects

The sample for this research was selected as a sample of convenience. Twenty - three subjects who volunteered from a population of thirty were selected for this thesis on the basis of their participation in three codependency treatment groups. Initially, two treatment groups, comprised of 15 members each from the Personal Development Centre, were selected for the sample; however, the second group was cancelled prior to its commencement. Two alternative groups were selected on the basis that members had experienced alcoholism in their childhood environments. An Adult Children of Alcoholics Branch of an Al-Anon group and an Al-A-Teen group were selected. Members who participated commented on the similarity between the questionnaire package and Step four in their Twelve Step Programs. Therefore, the two groups were considered to be reliable and representative of individuals experiencing codependency. Several of the subjects were known to the researcher.

The first group of subjects participating in an eight week introductory group for Adult Children of Alcoholics at the Personal Development Centre in Edmonton, was comprised of fourteen members and met one evening per week for two and a half hours. Verbal permission to conduct research with this group was given by the Director of the agency, the instructor of the group and the individuals group members.

The second group of subjects, selected on the basis of their participation and membership in an Adult Children of Alcoholics Al-A-Anon group in Calgary, was comprised of approximately twenty five members, with the attendance numbers varying from one week to the next. The group met for one hour on a weekly basis. On the evening the questionnaires were presented, 11 members were present and 11 packages were distributed. The respondents were known to the researcher. Verbal permission was given by the group members to conduct the research.

The third group of subjects were comprised of approximately twelve members of a Calgary Al-A-Teen group, with the attendance numbers again varying on a weekly basis. This group met once a week for one hour. Subjects were sixteen years of age and older to meet the age requirement of the Coopersmith Self-Esteem Inventory. Verbal permission to conduct the research was given by the group leader as well as the group members.

In total, 23 subjects responded to the questionnaires, 14 females and 9 males. Eight subjects out of a possible 14, responded from the Edmonton based treatment group, ten subjects responded from the Al-Anon group and five subjects responded from the Al-A-Teen group. The subjects ranged in age from 17 to 49 with a mean age of 29.52 and a SD of 9.11. Ten subjects were married, 11 were single and one was separated. One subject did not respond to the marital status question. In terms of occupation, subjects were placed into four categories based on their overall responses to the question. Five subjects were professionals, four were technical, six were clerical/homemakers and six were students. Two subjects did not respond. With respect to socioeconomic status, five subjects reported a yearly income of $0 - 9,999, one subject reported $10,000 - 14,999, one subject reported 15,000 - 19,999, two subjects reported 20,000 - 24,000, one subject reported 25,000 - 29,999, four subjects reported $30,000 - 34,999 and nine subjects reported an income of over $35,000.

Instruments

Five instruments were used: a demographic checklist, the Individual Outlook Test (I.O.T.) developed by Sim (1991), the Rotter Internal/External Locus of Control Scale (I/E Scale), the Internal Control Index (ICI) and the Coopersmith Self-Esteem Inventory Adult Form (SEI).

Demographic Checklist

The demographic checklist was administered in order to address the subjects' socio-economic status, gender, age, marital status and occupation. The demographic data was transferred to the computerized scanning sheet on which the subjects placed their answers to the 60 item IOT. The data was subject to computer analysis.

Validity of the Demographic Checklist

A study conducted on the relationship among economic and social factors contributing toward the development of deviant behavior found that the only significant demographic information was access to opportunity. This was identified through eight measures: age, marital status, language, occupation, education, religion and social participation. That is, the more access to opportunity, the more potential control over one's fate was perceived (Lefcourt, 1982).

Individual Outlook Test (I.O.T.)

The I.O.T. (Appendix A) has two versions, the 100 item and 60 item test. For the purpose of this thesis, this researcher selected the 60 item format given the reliability (r = .89) and validity of the instrument (Sim, 1991).

Scoring the I.O.T.

The scoring procedure for the I.O.T. involved responses to be recorded on a five-point Likert-type scale on a separate computer scanned answer sheet. The scoring procedure established by Sim utilized weightings of 5, 4, 3, 2, and 1 from strongly agree to strongly disagree on all items with the exception of 13 items which were reversed in order to prevent a response set. A high score will reflect a co-dependent orientation and a low score will not reflect this orientation.

Validity of the Individual Outlook Test (I.O.T.).

The validity of both the 100 item IOT and 60 item IOT was established by Sim (1991). Sim demonstrated the content validity:

1. through adherence to the specific content described in the literature;
2. through acceptance of only those items upon which three competent judges were in accord.

Criterion validity was also established:

1. through a criterion group test. To elaborate, a group of counsellees diagnosed as co-dependent or collaterals in an alcohol addicted family or dyad (n=45) were compared to a matched sample drawn from the norm group (n = 45). The codependent's scores were significantly higher (X = 189.02, SD = 39.57) than those of the matched sample (X = 153.60, SD = 27.15) (Worth, 1992, p. 59).

Reliability of the I.O.T.

Sim conducted a test-retest on both the 60 and 100 item

IOT questionnaires with a resulting reliability correlation coefficient of r = .89 and a Standard Error of Measurement of .33. A test of internal consistency was also completed; the resulting correlation coefficient was r = .88. According to Worth (1992), the test-retest Pearson Product Moment Correlation for the 60 item I.O.T. is r (300) = .98, Standard Error of Measurement = 4.14 and an internal consistency Cronbach Alpha Coefficient of r = .91 (pp. 50 - 51).

The Internal/External Control of Reinforcement Scale (I/E Scale).

The I/E Scale (Appendix B) is a measure of generalized expectancy of reinforcement (Rotter, 1966). It consists of 29 forced-choice pairs of internal statements paired with external statements, 23 of which are used for scoring purposes. Six filler items, numbers 1, 8, 14, 19, 24 and 27 are added in order to make the purpose of the test less obvious.

Scoring the I/E Scale

Response choices for the I/E Scale fell within a forced choice format. Responses were recorded on a computer scored answer sheet. Subjects were given one point for each external statement they selected. External statements were the second choice on items 3, 4, 5, 10, 11, 12, 13, 15, 22, 26 and 28 and the first choice on the remaining statements. A higher score reflected a greater tendency toward externality and scores ranged from 0 (internality) to 23 (externality).

Validity of the (I/E Scale)

The Rotter I/E Scale has reasonably high discriminate validity (Joe, 1971). Discriminate validity is indicated by the low relationships with variables such as intelligence and social desirability (Rotter, 1986, p. 25).

Construct validity has been established as the scale correlates satisfactorily with other methods of assessing the same variable including questionnaires, interview assessments and ratings from the story-completion technique (Campbell & Fiske, 1959). According to Rotter (1986) "the most significant evidence of the construct validity of the I/E Scale comes from predicted differences in behavior for individuals above and below the median of the scale or from correlations with behavioral criteria" (p. 25). Factor and item analysis indicate high internal consistency for an additive scale.

Reliability of the I/E Scale This scale has reasonably high reliability: the item and factor analysis show a reasonably high internal consistency reliability of .69 to .73 (Curtis, 1983); a test-retest reliability of .72 (Johnson, 1987) and a Kuder-Richardson internal consistency reliability of .70 (Johnson, 1987). In addition, the test-retest is consistent and satisfactory (between .49 and .83) for varying samples and intervening time periods (Hersch & Schiebe, 1967).

The Internal Control Index(ICI)

The ICI (Appendix C) is a measure of locus of control in adults and is based on the variables that are most relevant to internal locus of control, including cognitive processing, autonomy, resistance to influence attempts, delay of gratification and self-confidence (Duttweiler, 1984). It consists of 29 statements to which subjects were to decide what their normal or usual attitude, feeling or behavior would be.

Scoring the ICI

Responses ranged along a five point Likert type scale ranging from rarely to usually. Answers were recorded on a computer scored answer sheet. Those individuals who have an internal locus of control are expected to respond to approximately half the items at the usually end of the scale and the remaining half at the rarely end of the scale. Response weightings were 1, 2, 3, 4, 5, for items

3, 5, 7, 9, 10, 12, 13, 15, 16, 18, 20, 21, and 28 with the remaining items being reverse weighted. The score range is 28 to 140 (Andrew, 1992). The higher the score, the more internal the individual. Subjects who are in treatment for codependency, characterized by an external locus of control, would be expected to have a low score on the ICI.

Validity of the ICI

Construct validity was established through factor analysis. Two factors were identified: self-confidence, which accounted for 76.9 percent of the variance and autonomous behavior defined as behavior that is relatively independent of social reinforcement or social pressure, which accounted for 23.1 percent of the variance (Duttweiler, 1984). Content validity was also established by developing test items pertaining to an internal locus of control. A significant, but moderate negative Pearson Product Moment Correlation r = -0.385 was found between scores on the ICI and Mirel's Factor I of the Rotter I/E Scale. In addition, convergent validity was also established, as the negative correlation between a measure of external locus of control, the Rotter I/E was established (Andrew, 1992).

Reliability of the ICI

No test-retest correlations were reported. Cronbach Alpha reliability coefficients were $r = .84$ and $r = .85$ (Duttweiler, 1984).

The Coopersmith Self-Esteem Inventory (SEI)

The SEI (Appendix D) is designed to measure evaluative attitudes toward the self in social, academic, family and personal areas of experience. The adult form is used with persons aged 16 and above.

Scoring the SEI

The SEI consists of 25 items adapted from the school short form. Subjects are asked to respond to statements as to whether they are like or unlike them. Responses are scored with a scoring key.

Validity of the SEI

Validity has been established for the School Form of the SEI from which the Adult Form was adapted. Construct validity was established. Both Kimball (1972) and Kokenes (1974, 1978) "confirmed the construct validity of the subscales proposed by Coopersmith as measuring sources of self-esteem" (Coopersmith, 1967, p. 13).

Concurrent validity was established. Simon and Simon (1975) obtained a coefficient of .33 ($p<.01$) between the

SEI and the SRA Achievement Series. As well, the SEI scores were also correlated with their scores on the Lorge-Thorndike Intelligence Test with a coefficient of .30.

Predictive validity was established. "Regression analysis on the SEI subscale scores on MAT GES (Donaldson, 1974) indicated that the SEI is a fair predictor of reading achievement" with the Lie Scale being the best predictor. A factor analysis completed by Kokenes (1973) (n = 7600) revealed four pairs of factors, each congruent with the subscales of the SEI.

Reliability of the SEI

Bedeian, Geagud and Znud (1977) established Kuder-Richardson's of .74 for males and .71 for females. They also established test - retest reliability (n = 103) at .80 for males and .82 for females.

Given that the adult form was adapted from the School Form, the reliability for the School Form will also be presented. Internal consistency reliability was established. The KR20 reliability estimates were .81, .86 and .80 (Spatz & Johnson, 1973) and .87 and .92 (Kimball, 1972). Split-half reliability was established as .87 (Fullerton, 1972) and .90 (Taylor & Reitz, 1968).

Test retest reliability was established n = 50 at .88 (Coopersmith, 1967). It is important to note that the reliability will be somewhat lower for the Adult Form because of its shorter length.

Procedure

To ensure that all subjects taking part in this study received the same presenting information, the following script was followed by both group leaders and the researcher:

> As members of this group, you are being asked to participate in a thesis project being conducted by a graduate student from the University of Alberta. The thesis is on the topic of codependency and (in the case of other instructors presenting the information) I know this student personally. Each of you who wishes to participate is asked to complete a data collection package consisting of five questionnaires which should take no longer than 30 minutes of your time. Participation in this project is strictly confidential, you may choose not to participate or if you take a package to complete, may withdraw at any time. To allow for anonymity, data collection packages will be located on the table so those

> wishing to participate may take a package with you at the end of the group or meeting. For all who take a package, whether completed or not, please ensure that you return it to me at next week's meeting. For those or you who are unable to attend the next meeting, please return the information the following week.

The first group, from Edmonton, was approached about the study during their initial meeting. All documents were circulated during the initial meeting for the first group and collected during subsequent meetings. One package was returned by mail.

The second sample group, comprised of Al-A-Teen members, were approached by their group leader. The script was adhered to. All members 16 years and older participated in the study and the packages were returned to the group leader the following week who then forwarded them to this student. All packages were sealed to ensure their confidentiality.

The third group, comprised of Al-Anon members was approached by this researcher. Packages were circulated and returned during two subsequent meetings. One package was mailed. All packages were sealed.

Data Analysis

The level of significance for judging whether the characteristics of low self esteem and external locus of control were paramount for individuals identified as codependents was set at the .05 level. A correlational table was used to identify correlations between the I.O.T., I/E Scale, Internal Control Index and Self-Esteem Inventory. One way analysis of variances (ANOVAS) were used to test for group differences.

CHAPTER IV

Results

Introduction

The purpose of this section is to present the statistical findings related to each hypothesis. The four hypotheses were empirically tested using the Individual Outlook Test (IOT), Internal/External Scale of Reinforcement (I/E Scale), the Internal Control Index (ICI) and the Coopersmith Self Esteem Inventory (SEI).

Codependency was measured by responses to the IOT which was developed by Sim (1991). However, a limitation of Sim's research was the absence of a cutoff point for determining codependency on this instrument. To establish this point, two measures were taken on the basis of Sim's norming group on the IOT (x = 158.15, SD = 26.98). The first measure taken was one SD above Sim's mean, a score of 185. The second measure taken was a half SD above Sim's mean, a score of 172. Both measures were used to compile the results and a similar trend emerged in the findings. Therefore, for this research, one SD above Sim's mean, a score of 185 or greater, was determined to be the cutoff point for determining codependency on the responses to the IOT. Responses to the IOT were divided into two groups, those scoring 185 or greater, the codependent group and those scoring less than 185, the non-codependent group. Subjects whose scores placed them within the codependent group had a mean of 221.53 and SD of 15.80 on the IOT. Subjects whose scores placed them within the non-codependent group had a mean of 161.13 and SD of 24.46. To assess for group differences, one-way analysis of variances were used. A correlational analysis was used to determine relationships between the instruments.

The sample for this research (n = 23) had an overall mean of 200.52 and a SD of 34.85 on their responses to the IOT. This group was stronger than the codependent group (n = 107) used by Sim to obtain her results. (x = 179.83, SD = 48.68). The sample is outlined in Table 1.

Table 1

Description of Sample

Demographics	Category	# of Subjects	% of Sample
Sex	Male	9	39.1
	Female	14	60.9
Marital Status	Married	10	45.5
	Common - Law	0	0
	Single	11	50
	Separated	1	4.5
	Divorced	0	0
	Widowed	0	0
	No Response	1	.5
Occupation	Professional	5	21.7
	Technical	4	17.4
	Clerical/Homemaker	6	26.1
	Student	6	26.1
	No Response	2	8.7

Income	$0 - 9,999	5	18.2
	$10,000 - 14,999	1	4.5
	$15,000 - 19,999	1	4.5
	$20,000 - 24,999	2	9.1
	$25,000 - 29,999	1	4.5
	$30,000 - 34,999	4	18.2
	$35,000 - over	9	40.9

Hypothesis 1

There Will Be A Significant Difference Between the Responses of the Two Groups on the SEI.

A one-way analysis of variance (ANOVA) was conducted to test this hypothesis. A sample of 23 subjects was divided into two groups, codependent and non - codependent, based on their responses to the IOT. 15 subjects, with a mean of 221.53 and SD of 15.80, were determined to be codependent. Eight subjects, with a mean of 161.13 and SD of 24.46, were determined to be non-codependent. According to the data in Table 2, there is a significant difference ($p = .0001$) between the responses of the two groups on the SEI. Subjects in the codependent group, scored low on the SEI (low self esteem) with a mean of 30.67 and a SD of 15.47 on the SEI. Subjects in the non-codependent group scored high (high self esteem) on the SEI with a mean of 77.0 and a SD of 14.62 on the SEI.

Table 2

One Way (ANOVA) SEI By Codependent Group (IOT)

SOURCE	df	SS	MS	F
BETWEEN	1	11200.58	11200.58	48.544
WITHIN	21	4845.33	230.73	P= .0001
TOTAL	22	16045.91		

Hypothesis 2

There Will Be A Significant Difference Between the Responses of the Two Groups 1) on the I/E Scale and 2) on the ICI.

A one-way ANOVA was conducted to test both components of the hypothesis. A significant difference between the two groups' responses on the I/E Scale was not observed. (p = .625). The results are presented in Table 3. Subjects (n = 8) in the non-codependent group had a mean of 10.13 and SD of 4.39 on the I/E Scale. Subjects (n = 15) in the codependent group had a mean of 10.87 and a SD of 2.80 on the I/E Scale.

Table 3

One Way ANOVA I/E BY Codependent Group (IOT)

SOURCE	df	SS	MS	F
BETWEEN	1	2.87		.246
WITHIN	21	244.61	11.65	P = .625
TOTAL	22	247.48		

There is a significant difference (p = .010) between the responses of the two groups on the ICI as shown in Table 4. Subjects (n = 8) in the non-codependent group had a mean of 105.25 and a SD of 8.78 on the ICI. Subjects (n = 15) in the codependent group had a mean of 88.07 and a SD of 15.90 on the ICI.

Table 4

One Way (ANOVA) ICI By Codependent Group (IOT)

SOURCE	df	SS	MS	F
BETWEEN	1	1540.52	1540.52	7.936
WITHIN	21	4076.43	194.12	P = .010
TOTAL	22	5616.96		

The inverse was also tested; that is, a high score, reflecting greater internality on the ICI, would be expected to correspond with a low score on the IOT.

Subjects were divided into two groups based on their responses on the ICI. In order to identify these two groups, the distribution of scores on the ICI was examined and divided at a naturally occurring cutoff point in the distribution which was a score of 80. Eight subjects scored low on the ICI (the external group), 15 subjects scored high (the internal group). Subjects who scored low on the ICI (external group) had a mean of 75.88 and SD of 4.29. Subjects who scored high on the ICI (internals) had a mean of 103.73 and SD of 10.14. There was a significant difference (p= .0025) between the responses of the two groups. Subjects who scored low on the IOT had a mean of 228.5 and SD of 15.46 on the ICI. Subjects who scored high on the IOT had a mean of 185.6 and SD of 33.22 on the ICI. The data are presented in Table 5.

Table 5

One Way ANOVA I.O.T X ICI Group

SOURCE	df	SS	MS	F
BETWEEN	1	9602.14	9602.14	11.779
WITHIN	21	17119.60	815.22	P = .0025
TOTAL	22	26721.74		

Hypothesis 3

There Will Be A Significant Relationship Between the ICI and I/E Scale.

Given that both the ICI and I/E Scale are measures of locus of control, it was expected that there would be a significant relationship between the two instruments. Critical values (df = 21) for determining the level of significance for the correlational table were established at four levels:

$p = .05$	.352	$p = .010$	.482
$p = .025$	.413	$p = .005$	.526

The level of significance was set at $p = .05$; therefore, any value less than .352 would not be considered significant at the .05 level. There is not a significant relationship *r*(-.243) between the two measures as shown in Table 6.

Table 6

Correlational Analysis of the IOT, I/E, ICI and SEI

	IOT	ICI	I/E	SEI
IOT				
ICI	-.586			
I/E	.213	-.243		
SEI	-.873	.717	-.297	

Hypothesis 4

There Will Be a Significant Relationship Between the SEI, I/E Scale, ICI and IOT.

There are significant relationships between the IOT and the SEI *r*(-.873) and between the IOT and ICI r(-.586) at the .005 level of significance. (Table 6). There was not a significant relationship between the IOT and I/E Scale r(-.213), the ICI and I/E Scale r(-.243) and the CSI and I/E Scale r(-.297) at the .05 level.

There is also a significant relationship between the ICI and the SEI r(.717) at the .005 level. A one-way ANOVA (Table 7) between the ICI and SEI was also conducted. Subjects were divided into two groups based on their responses to the ICI. Subjects whose scores were low on the ICI (external group) had a mean of 75.88 and SD of 4.29. Subjects whose scores were high on the ICI (internal group) had a mean of 103.73 and SD of 10.14. There was a significant difference (p= .0005) between the responses of the two groups on the SEI. Subjects who scored low on the ICI (externals) had a mean of 22.50 and SD of 14.33 on the SEI. Subjects who scored high on the ICI (internals) had a mean of 59.73 and SD of 22.95 on the SEI.

Table 7

One Way ANOVA SEI X ICI group

SOURCE	df	SS	MS	F
BETWEEN	1	7332.98	7332.98	17.235
WITHIN	21	8812.93	419.66	P = .0005
TOTAL	22	16045.91		

Demographic Findings

One-way analysis of variances (ANOVA) were conducted between the demographic information, IOT, I/E, ICI and SEI in order to determine if responses were in any way affected by gender, age, marital status, occupation or income. Gender was determined to have a significant effect on both the IOT and SEI. With respect to the IOT, there was a significant difference (p = .0038) in the responses of males and females on the IOT. (Table 8). Male subjects (n = 9) had a mean of 175.89 and SD of 37.57 on the IOT. Female subjects (n = 14) had a mean of 216.36 and SD of 22.29 on the IOT.

Table 8

One Way Analysis of Variance (ANOVA) IOT & Gender

SOURCE	df	SS	MS	F
BETWEEN	1	8971.64	8971.64	10.614
WITHIN	21	17750.10	845.24	P = .0038
TOTAL	22	26721.74		

There was also a significant difference (p = .058) between the responses of males and females to self esteem as measured by the SEI. (Table 9). Male subjects had a mean of 60.0 and SD of 30.27 on the SEI. Female subjects had a mean of 38.29 and SD of 21.72 on the SEI.

Table 9

One Way Analysis of Variance (ANOVA) SEI & Gender

SOURCE	df	SS	MS	F
BETWEEN	1	2583.06	2583.06	4.03
WITHIN	21	13462.86	641.09	P = .058
TOTAL	22	16045.91		

CHAPTER V

DISCUSSION AND LIMITATIONS

The intent of this thesis was to address four questions through the empirical testing of four hypotheses. The questions asked included the following:

1. Do codependent individuals identify with low self esteem?;
2. Do codependent individuals identify with an external locus of control?;
3. Will there be a significant relationship between low self esteem, external locus of control and codependency?;
4. Will there be a significant relationship between the I/E Scale and the ICI as they both are measures of locus of control?.

Delimitations

The main goal of this research was to establish whether the characteristics of low self-esteem and external locus of control were related to codependency as stated by the majority of codependency authors and practitioners. A sample of 23 subjects, out of a population of 30, from three codependency treatment groups, volunteered for the study. Four hypotheses were tested and their findings are presented.

Conclusions

The hypothesis that there would be a significant difference between the responses of the two groups on the SEI was accepted. Those subjects in the codependent group identified with low self-esteem as indicated by their low scores on the SEI. Those in the non-codependent group identified with high self-esteem as indicated by their high scores on the SEI.

The hypothesis that there would be a significant difference between the responses of the two groups on the I/E Scale was rejected. There was not a significant difference between the codependent and non-codependent group in terms of their responses to the I/E Scale.

The hypothesis that there would be a significant difference between the responses of the two groups on the ICI was accepted. Those subjects in the codependent group, scored low on the ICI which is a measure of external orientation. Those subjects in the non-codependent group, scored high on the ICI, reflecting a more internal orientation.

The hypothesis that there would be a significant relationship between the four instruments used, the SEI, IOT, I/E Scale and ICI was rejected. There were significant relationships between the SEI, IOT and ICI instruments; however, the I/E Scale was not significantly correlated with any other instrument.

The hypothesis that there would be a significant negative relationship between the I/E Scale and the ICI given that they were both measures of locus of control was rejected. A significant correlation was not found.

In terms of demographic findings, gender had a significant effect on self esteem and locus of control. That is, males were significantly more likely to identify with high self esteem, whereas females identified with low self esteem. As well, males tended to identify with an internal locus of control and females identified with an external locus of control. Gender also had a strong effect on the IOT in that females scored more in the direction of codependence than males.

Limitations

There are several limitations inherent in this study that are acknowledged by this researcher. These include adminstration conditions, sampling strategy, the use of the I/E Scale and gender effects.

With respect to procedural limitations, this researcher did not administer the questionnaires to the Edmonton or Al-A-Teen groups. Rather, leaders of the groups, who were well-known to the researcher, were provided with scripts so that each group received the same information. However, it is recognized that factors including personality, effectiveness of presentation and ability to motivate group members to participate could not be controlled.

With respect to sampling strategy, the use of a volunteer as opposed to non-volunteer sample poses limitations.

The I/E Scale proved to be a disappointing measure as several of the hypotheses were rejected due to the use of this instrument. The lack of significance in several results was likely due to the inadequacy of the I/E instrument given its forced-choice format as compared to the five point Likert type scale of the ICI. As this researcher was uncertain about the instrument in the early stages of this study, a second instrument, the ICI, was selected to address locus of control.

There were significant differences in the way males and females responded to the IOT and SEI. Given that there was a higher number of female subjects than male, it would be interesting to determine if similar results would emerge with an equal number of male subjects.

Implications for Practice

The characteristics of low self esteem and external locus of control were determined to be significantly related to codependency. Establishing these two characteristics as certainties allows those in the helping profession to address specific areas of treatment. However, practitioners should be cautious when labelling an individual as codependent as there is an implication that the concept may simply be a "catch - all" term to encompass a variety of intra and interpersonal difficulties which are well known to helping professionals.

There are several issues related to codependency that warrant discussion: the value of the label and the method of treatment. The use of the codependency label has had both a positive and negative impact. With respect to the positive effects, when codependency was first introduced, it received considerable attention and a substantial number of people began the recovery process that may have otherwise not received assistance for their personal difficulties. Most importantly, the label provided people with meaning to their experiences, a universal need for all individuals.

In terms of its negative impact, individuals in recovery have tended to become stuck in treatment because it is stated in the codependency literature that if an individual leaves treatment, he/she has returned to a state of denial. As well, within the addictions field, there has been a tendency to label individuals ie) alcoholic, and for those labels to be assumed for the rest of one's life. Until recently, little or no research has been conducted concerning how to move beyond the codependency label and how to integrate the knowledge about codependency into one's life. Furthermore, any desire to move beyond the label has met with resistance from the recovery community.

The label appears to have particulary detrimental effects on women. According to Van Wormer (1990), "the concept of codependency is used in a discriminatory way against women as [it] has socio-political roots in sexism and the oppression of women" (p. 52). She states that the characteristics of codependency are essentially exaggerations of womens' prescribed cultural role and that "the high frequency with which the codependence label is used for female clients is suggestive of an overlap between the central dynamics of codependency and key dimensions in the sex-role socialization of women" (p. 55).

Asher and Brissett (1988) indicate that codependency reinforces the traditional, passive role of women. They state that "when a woman takes on the identity of codependent, she is accepting the fact that who she is depends on to whom she is/was married" (p. 348). Van Wormer (1990) would state that this exemplifies the shortcoming of the codependency literature in that it fails to address the social and political context in which women are living today and have lived formerly. That is, given social, economic and political changes, women may tend to be less traditional and more active than passive in creating their own identities and lives. Codependency, Van Wormer (1990) states, is just another in a long line of concepts such as hysteria and histrionic personality used to categorize the problems of women. She concludes that women are harmed by therapists who persuade them to feel guilty for being married to an alcoholic and harmed in being diagnosed as showing pathology when they react normally to an extreme situation.

Another key issue with respect to codependency is the method of treatment. The primary mode of recovery has been the use of Twelve Step programs and inner child work. Again, as with the treatment of alcoholism, the premise is that there is no cure and that an individual in treatment for codependency requires life-long intervention. There has been considerable resistance to alternative methods of treatment both from professionals in the addictions field as well as from advocates of the Alcoholics Anonymous movement. Furthermore, little or no research has been conducted with respect to the issue of prevention for children and/or adolescents in developing codependent behaviors.

In conclusion, codependency is not believed to be a new phenomenon. Rather, it is likely a concept that has been developed to describe basic psychological issues which have been familiar to therapists for years. It is also worth noting that the concept may be flawed due to its irrefutability. That is, if an individual is identified as being codependent, he/she is recommended for treatment and as there is no cure, a life long recovery process is advocated. If the individual attempts to terminate treatment, he/she is advised that denial has occurred and that further intervention is required. Most importantly, criticism of the concept by others in the addictions field is defended and it has been suggested that authors who criticize the codependency literature have unresolved issues of their own.

Finally, it is unlikely that codependency is only based on a reaction to living with the problem of alcoholism. On the basis of the literature, the development of low self esteem and external locus of control can occur in any unhealthy, maladaptive environment. Alcoholism is just one of those environments and is, in itself, a symptom of a unhealthy family system. Although an important contribution to addictions treatment and research, codependency will likely fade in popularity and will become a stepping stone to further developments in the addictions field.

Implications for Research

Considerable research continues to be required to determine a definition of codependency as well as to determine additional characteristics through empirical research. Further research also needs to address the issue of gender as males need to be represented proportionately to females in future studies. The I/E Scale is not recommended as a measure of locus of control in future research.

References

Ackerman, N. W. (1958). The Psychodynamics of Family Life: Diagnosis of Family Relationships. NY: Basic Books, Inc.

Ackerman, R. J. (1983). Children of Alcoholics (2nd Ed.). Florida: Learning Publications, Inc.

Ackerman, R. J. & Gondolf, E.W. (1991). The Effects of Background and Treatment on ACOA Symptoms. The International Journal of Addictions, 26(11), 1159-1172.

Ainsworth, M. D. S. (1973). The Development of Infant-Mother Attachment. In B. M. Caldwell and H. N. Ricciuti (eds.). Review of Child Development Research, 3, Chicago: Chicago University Press.

Allport, G.W. (1967). Pattern and Growth in Personality. New York: Holt, Rinehart and Winston.

American Psychiatric Association (1987). Diagnostic and Statistical Manual of Mental Disorders (3rd Ed., rev.). Washington, D.C.: Author.

American Psychological Association (1983). Publication Manual (3rd Ed.). Washington, D.C.: Author.

Ashkam, J. (1976). Identity and Stability Within the Marriage Relationship. Journal of Marriage and the Family, 38, 535-547.

Bandura, A. (1964). The Stormy Decade. Fact or Fiction? Psychology in the School, 1, 224-31.

Beane, J. A. & Lipka, R. P. (1986). Self-Concept, Self-Esteem, and the Curriculum. New York: Teachers College Press.

Beattie, M. (1987). Codependent No More. New York: Harper and Row, Publishers Inc.

Bee, H. The Developing Child. (3rd Ed.). (1981). New York: Harper & Row, Publishers.

Beletsis, S. & Brown, S. Adult Children of Alcoholics in Treatment. In A Developmental Framework for Understanding the Adult Children of Alcoholics. (pamphlet).

Bell, S. M. & Ainsworth, M. D. S. (1972). Infant Crying and Maternal Responsiveness. Child Development, 43, 1171-1190.

Benedek, T. (1938). Adaptation to Reality in Early Infancy, Psychoanalytic Quarterly, 7, 200-15.

Black, C. (1981). It Will Never Happen To Me. CO: Medical Administration Company.

Bowen, M. (1978). Family Therapy in Clinical Practice. New York: Aronson.

Bowlby, J. (1969). Attachment and Loss (Vol. I). Attachment. NY: Basic Books.

Bradshaw, J. (1988). Healing the Shame That Binds You. Florida: Health Communications, Inc.

Bradshaw, J. (1990). Bradshaw on HomeComing - Television Special. March 8-9. 1992.

Brissett, M. & Nowicki, S. (1973). Internal vs. External Control of Reinforcement and Reaction to Frustration, Journal of Personality and Social Psychology, 25, pp. 35-44.

Bryant, B. K. (1974). Locus of Control Related To Teacher-Child Interperceptual Experiences. Child Development, 45, 157-164.

Butterfield, E.C. (1964). Locus of Control, Test Anxiety, Reaction to Frustration and Achievement Attitudes, Journal of Personality, 32, pp. 298 - 311.

Cantril, H. (1964). A Fresh Look at the Human Design. Journal of Individual Psychology, 20, 129-136.

Cermack T.L. & Brown S. (1982). Interactional Group Therapy With the Adult Children of Alcoholics. International Journal of Group Psychotherapy, 32(3), pp. 375-389.

Cermack, T. L. (1986). Diagnosing and Treating Co-Dependence: A Guide for Professionals Who Work With Chemical Dependents, Their Spouses and Children. Minnesota: Johnson Institute Books.

Cermack, T. L. & Rosenfeld, A. A. (1987). Therapeutic Considerations With Adult Children of Alcoholics. In B. Stimmel (Ed.). Children of Alcoholics (pp.

17-27). NY: The Haworth Press, Inc.

Cermack, T. L. (1988). A Time to Heal: The Road to Recovery for Adult Children of Alcoholics. NY: St. Martin's Press.

Cermack, T. L. (1991). Co-Addiction As A Disease. Psychiatric Annals, 21(5), 266-272.

Chance, J.E. (1965). Internal Control of Reinforcement and the School Learning Process. Paper Presented at the Biennial Meeting of the Society for Research in Child Development. Minneapolis.

Christensen, H. T. (1967). Handbook of Marriage and the Family. Chicago: Rand McNally & Company.

Clarke-Stewart, A. & Friedman, S. (1987). Child Development: Infancy Through Adolescence. NY: John Wiley & Sons.

Clemes, H. & Bean, R. (1983). How To Raise Children's Self-Esteem. CA: Enrich.

Cocores, J. (1987). Co-Addiction: A Silent Epidemic, Psychiatry Letter, 5, 5-8.

Coopersmith, S. (1967). The Antecedents of Self-Esteem. San Francisco: W.H. Freeman and Company.

Covington, S. & Beckett, L. (1988). Leaving the Enchanted Forest: The Path From Relationship Addiction to Intimacy. San Francisco: Harper & Row, Publishers.

Crain, W.C. (1980). Theories of Development: Concepts and Applications. New Jersey: Prentice-Hall, Inc.

Crandall, V.C., Kotkovsky, W. & Crandall, V.J. (1965). Children's Beliefs in Their Own Control of Reinforcement in Intellectual Academic Situations, Child Development, 36, pp. 31-109.

Dager, E.Z. (1967). Socialization and Personality Development in the Child. In H.T. Christensen (Ed.). Handbook of Marriage and the Family. (pp. 740 - 781). Chicago: Rand McNally & Company.

Davis, W.L. & Phares, E.J. (1967). Internal/External Control As a Determinant of Information Seeking in a Social Influence Situation, Journal of Personality, 35, pp. 547-561.

Davis, W.L. & Phares, E.J. (1969). Parental Antecedents of Internal/External Control of Reinforcement, Psychological Reports, 24, pp. 427-436.

Dweck, C. S. & Licht, B. (1980). Learned Helplessness and Intellectual Achievement. In J. Garber and M. Seligman (Eds.). Human Helplessness. NY: Academic Press.

Elkind, D. (1967). Egocentrism in Adolescence. Child Development, 38, 1025-1034.

Elkind, D. (1970). Children and Adolescents. NY: Oxford University Press.

Epstein, N. B. et al. (1982). McMaster Model of Family Functioning: A View of the Normal Family. In Froma Walsh, ed., Normal Family Processes. NY: Guilford Press.

Erikson, E. (1959). Identity and the Life Cycle. Psychological Issues, Monograph I, Vol. I. NY: International University Press.

Erikson, E. (1968). Identity, Youth and Crisis. NY: Norton.

Fenigstein, A., Scheier, M. F. & Buss, A. H. (1975). Public and Private Self-Consciousness: Assessment and Theory. Journal of Counseling and Clinical Psychology, 43, 522-527.

Fitch, G. (1970). Effects of Self-Esteem, Perceived Performance and Choice on Causal Attributions, Journal of Personality & Social Psychology, 16, pp. 311-315.

Franklin, R. D. (1963). Youth's Expectancies About Internal versus External Control of Reinforcement. Dissertation Abstracts, 24, 1684.

Freud, A. (1972). Adolescence. In J. F. Rosenblith, W. Alinsmith, and J. P. Williams (Eds.)., The Causes of Behavior (3rd Ed.). Boston: Allyn & Bacon.

Friel, J. & Friel, L. (1990). An Adult Child's Guide to What's Normal. Florida: Health Communications, Inc.

Gebhard, P. (1977). The Acquisition of Basic Sex Information. Journal of Sex Research, 13(3), 148-169.

Geringer-Woititz, J. (1983). Adult Children of Alcoholics. FL: Health Communications, Inc.

Gravitz, H. L. & Bowden, J. D. (1985). Recovery: A Guide for Adult Children of Alcoholics. New York: Simon & Schuster, Inc.

Hall, G. S. (1904). Adolescence, Vol. 1. NY: D. Appleton.

Hall, T. (1988, October). Increasingly, Bad Habits Are Labelled Addictions. New York Times, p. B8.

Harrow, M. & Ferrante, A. (1969). Locus of Control in Psychiatric Patients, Journal of Consulting and Clinical Psychology, 33, pp. 582-589.

Hauntras, P. T. & Scharf, M. C. (1970). Manifest Anxiety and Locus of Control of Low-Achieving College Males. Journal of Psychology, 74, 95-100.

Havighurst, R. J. (1953). Human Development and Education. NY: Longmans, Green & Co.

Hemfelt, R., Minirth, F. & Meier, P. (1989). Love is a Choice: Recovery for Codependent Relationships. Nashville: Thomas Nelson Publishers.

Hergenhahn, B. R. (1988). (3rd Ed.). An Introduction to Theories of Learning. New Jersey: Prentice Hall, Inc.

Hersch, P. D. & Scheibe, K. E. (1967). Reliability and Validity of Internal/External Control as a Personality Dimension. Journal of Consulting Psychology, 31, 609-613.

Hill, R. & Hansen, D. (1960). The Identification of Conceptual Frameworks Utilized in Family Study. Marriage and Family Living, 22, 299-311.

Hollingworth. (1928). Psychology of the Adolescent. NJ: Appleton.

Inhelder, B. & Piaget, J. (1955). The Growth of Logical Thinking From Childhood to Adolescence. (A. Parsons and S. Milgram, trans.). NY: Basic Books.

Jackson, J. K. (1954). The Adjustment of the Family to the Crisis of Alcoholism. Quarterly Journal of Studies on Alcohol, 15, 562-586.

Kagan, J. (1976). The Psychological Requirements for Human Development. In Nathan Talbot, ed., Raising Children in Modern America. Boston: Little, Brown and Company.

Katkovsky, W. Crandall, V.C. & Good S. (1967). Parental Antecedents of Children's Beliefs in Internal/External Control of Reinforcement in Intellectual Achievement Situations, Child Development, 38, pp. 765-776.

Larson, E. (1983). Basics of Codependency. MN: E. Larson Enterprises.

Lefcourt, H. M. (1982). Locus of Control. (2nd. Ed.). New Jersey: Lawrence Erlbaum Associates, Publishers.

Lerner, H. E. (1975). And What Do Little Girls Have: Some Thoughts on Female Sexuality. Behold the Woman: 5-6.

Levenson, H. (1973). Multidimensional Locus of Control in Psychiatric Patients. Journal of Consulting and Clinical Psychology, 41, 397-404.

Lewis, J. M. et al. (1976). No Single Thread. NY: Brunner/Mazel.

Lewis, M. & Rosenblum, L. A. (Eds.). (1979). The Child and Its Family. NY: Plenum Press.

Lisansky Gomberg, E. S. (1989). On Terms Used and Abused: The Concept of "Codependency", Drugs and Society, 3, 113-132.

Lord, L. et al. (1987). Coming To Grips With Alcoholism. U.S. News & World Report, 56-62.

Maccoby, E. E. (1961). Choice of Variables in the Study of Socialization. Sociometry, 24, 357-371.

Maher, T.P. (1966). Self - A Measureless Sea. St. Louis: Catholic Hospital Association.

Maslow, A. (1970). Motivation and Personality. (2nd Ed.). NY: Harper and Row, Pub.

Matteson, R. (1974). Adolescent Self-Esteem, Family Communication, and Marital Satisfaction. Journal of Psychology, 86, 35-47.

McKay M. & Fanning, P. (1987). Self-Esteem. CA: New Harbinger Publications.

Meeks, D.E. & Kelly, C. (1970). Family Therapy With the Families of Recovering Alcoholics. Quarterly Journal of Studies on Alcohol, 31, 499-413.

Mellody, P. (1989). Facing Codependence. New York: Harper and Row, Publishers, Inc.

Miller, P. H., Kessell, F.S. & Flavell, J. H. (1970). Thinking About People Thinking About People Thinking About...A Study of Social Cognitive Development. Child Development, 41, 613-623.

Minuchin, S. (1974). Families and Family Therapy. Mass: Harvard University Press.

Mitchell, J.J. (1975). The Adolescent Predicament. Toronto: Holt, Rinehart and Winston of Canada, Limited.

Montagu, A. (1986). Touching: The Human Significance of the Skin. (3rd Ed.). NY: Harper and Row.

Olson, S. L., Bates, J. E. & Bayles, K. (1984). Mother-Infant Interaction and the Development of Individual Differences in Children's Cognitive Competence. Developmental Psychology, 20, 166-179.

Parsons, T. & Bales, R. F. (1955). Family: Socialization and Interaction Process. Illinois: Free Press.

Phares, E.J. (1976). Locus of Control in Personality. New Jersey: General Learning Press.

Piaget, J. (1936). The Construction of Reality in the Child. (M. Cook, trans.). NY: Ballantine Books.

Pogrebin, L. C. (1983). Family Politics. NY: McGraw-Hill.

Richardson, R.W. (1987). Family Ties That Bind. (2nd Ed.). Vancouver: Self-Counsel Press.

Rosenberg, M. (1965). Society and the Adolescent Self-Image. NJ: Princeton University Press.

Rotter, J. B. (1966). Generalized Expectancies for Internal vs. External Control of Reinforcement, Psychological Monographs, 80, (1, Whole No. 609).

Rousseau, J. J. (1762). The Social Contract. (G. Hopkins, trans.). NY: Oxford University Press.

Royce, J.E. (1981). Alcohol Problems and Alcoholism. N.Y.: The Free Press.

Russell, A. (1989). Self-Esteem. Manitoba: Peguis Publishers Limited.

Satir, V. (1972). Peoplemaking. CA: Science and Behavior Books, Inc.

Satir, V. (1975). Celestial Arts. CA.

Satir, V. (1988). The New Peoplemaking Book. CA: Science and Behavior Books.

Schachtel, E. G. (1959). Metamorphosis. NY: Basic Books.

Sears, R. R. (1970). Relation of Early Socialization Experiences to Self-Concepts and Gender Roles in Middle Childhood. Child Development, 41, 267-289.

Seeman, M. (1959). On The Meaning of Alienation. America Sociological Review, 24, 783-791.

Seeman, M. (1967). Powerlessness & Knowledge: A Comparative Study of Alienation and Learning. Sociometry, 30, 105-123.

Smith, C. B., Adamson, L. B., & Bakeman, R. (1986). Interactional Predictors of Early Language. Infant Behavior and Development, 9, 347.

Stinette, N. & Defrain, J. (1958). Secrets of Strong Families. Boston: Little, Brown and Company.

Stringer, L.A. (1971). The Sense of Self. Philadelphia: Temple University Press.

Strong, B. & DeVault, C. (1989). The Marriage and Family Experience. (4th Ed.). New York: West Publishing Company.

Typpo, M. H. & Hastings, J. M. (1984). An Elephant in the Living Room. Minnesota: CompCare Publishers.

Van Wormer, K. (1990). Co-dependency: Implications for Women and Therapy, Women and Therapy, 8(4), 51-63.

Wegscheider, S. (1981). Another Chance. Hope and Health for the Alcoholic Family. CA: Science and Behavior Books.

Whitfield, C. (1984). Co-dependency: An Emerging Problem Among Professionals. In Co-dependency: An Emerging Issue. FL: Health Communications, p. 45.

Whitfield, C. (1987). Healing the Child Within. Florida: Health Communications, Inc.

Wilson Schaef, A. (1986). Co-dependence: Misunderstood-Mistreated. Minneapolis: Winston Press.

Wilson Schaef, A. (1987). When Society Becomes An Addict. San Francisco: Harper and Row, Publishers, Inc.

Winnicott, D.W. (1965). The Family and Individual Development. London: Tavistock Publications Limited.

Wylie, R.C. (1961). The Self-Concept: A Critical Survey of Pertinent Research Literature. Lincoln: University of Nebraska.

APPENDIX A

60 - ITEM INDIVIDUAL OUTLOOK TEST (IOT)

Directions:

Please read each statement and rate how each statement reflects your normal or usual attitude, feeling or behavior according to the following scale:

(A)	(B)	(C)	(D)	(E)
Strongly Agree	Agree	Neutral/ Undecided	Disagree	Strongly Disagree

1. I sometimes feel that I'm not good enough to associate with the people I meet.
2. I never try to help people unless I'm asked.
3. I have often done things without thinking them through properly and later regretted my decision.
4. I feel anxious or tense about something or someone almost all the time.
5. I had a happier childhood than most other people.
6. I have had partners who didn't treat me very well.
7. It seems to me I have spent my whole life trying to please others.
8. Although I appear strong and capable to others, there is a part of me that isn't strong at all.
9. I have been close to people who did illegal things and I found excuses for what they did.
10. Often when asked for my opinion, I found out what other people think before I say what I think.
11. I often feel there is something bad about me.
12. I am not ashamed of my childhood.
13. I can't remember the last time I felt totally carefree and relaxed.

14. Sometimes I don't know who the real me is.

15. I have on many occasions, checked up to see where my partner is when he or she is not with me.

16. I tend to believe things people say and often find out later that they have lied.

17. I have trouble thinking of the right things to say when in a group of people.

18. I feel I fit in at most social gatherings.

19. I feel best about myself when I'm having a romantic relationship.

20. Often, others find things amusing that I don't consider funny.

21. Even a small kindness from a person I've had a problem with, makes me forgive and forget.

22. I don't undertake any project unless I'm pretty sure I'll succeed.

23. There are things I have done or had happen to me in the past that I am ashamed to talk about.

24. I have often said hurtful things to people I love in order to get them to listen.

25. I am embarrassed when people give me compliments but secretly I feel good.

26. I can be easily swayed from doing something if others criticize it.

27. When things go wrong for others, I often blame myself even when I shouldn't.

28. I don't worry very much about what the future hold for me.

29. When I am in a relationship, I am totally involved in it and expect the same from my partner.

30. Quite often I lose sleep worrying about people who are important to me.

31. I quite often feel as if something dreadful is going to happen.

32. When I feel I have insulted a person, I feel ill until I make the matter right.

33. I sell myself short and settle for less than the best in romantic partners.

34. I have lied to protect people who are important to me.

35. I was raised in a family where physical abuse occurred.

36. I need a lot of reassurance that people like me.

37. It is hard for me to ask for help from someone unless I know I can return the favour.

38. When even little things go wrong, I usually get very upset and stay upset until everything is fine again.

39. Often I feel so nervous and tense that I feel dizzy.

40. I rarely go out or do anything without my partner.

41. I am envious of most of the people I meet.

42. If I am embarrassed or feel foolish, I worry about it for days.

43. Some days there seem to be so many things going wrong that life seems hopeless.

44. Sometimes I have so many thoughts racing through my head that I can't make sense out of them.

45. When I meet someone who has a problem, I often try to help them even before they ask.

46. I am never concerned about whether people like me or not.

47. I have often gone to see a doctor about my depression.

48. I don't let people get to know the real me.

49. There have been times when my life has seemed so depressing that I have thought of ending it.

50. As a child, my parents seldom listened to what I had to say or how I felt.

51. I do not like people criticizing me even if they may be right.

52. When I am alone, I often feel desperate to have company.

53. Most people cannot be truly trusted.

54. It bothers my if my romantic partner wants to go out or do something without me.

55. If someone criticizes me, I tend to believe them and then try to change myself.

56. My feelings and behavior are mostly controlled by the people around me.

57. One of my greatest worries is that some of the people I care about may leave me.

58. I have done things I am not very proud of in order to keep a relationship together.

59. I often feel as if I haven't begun to live yet.

60. I often feel anxious and uptight and can't figure out why.

APPENDIX B

I/E SCALE

1. 1. Children get into trouble because their parents punish them too much.
   2. The trouble with most children nowadays is that their parents are too easy with them.

2. 1. Many of the unhappy things in people's lives are partly due to bad luck.
   2. People's misfortunes result from the mistakes they make.

3. 1. One of the major reasons why we have wars is because people don't take enough interest in politics.
   2. There will always be wars, no matter how hard people try to prevent them.

4. 1. In the long run people get the respect they deserve in this world.
   2. Unfortunately, an individual's worth often passes unrecognized no matter how hard he tries.

5. 1. The idea that teachers are unfair to students in nonsense.
   2. Most students don't realize the extent to which their grades are influenced by accidental happenings.

6. 1. Without the right breaks, one cannot be an effective leader.
   2. Capable people who fail to become leaders have not taken advantage of the opportunities.

7. 1. No matter how hard you try some people just don't like you.
   2. People who can't get others to like them don't understand how to get along with others.

8. 1. Heredity plays the major role in determining one's personality.
   2. It is one's experiences in life which determine what they're like.

9. 1. I have often found that what is going to happen will happen.
   2. Trusting to fate has never turned out as well for me as making a decision to take a definite

course of action.

10. 1. In the case of the well prepared student there is rarely if ever such a thing as an unfair test.
    2. Many times exam questions tend to be so unrelated to course work that studying is really useless.

11. 1. Becoming a success is a matter of hard work, luck has little or nothing to do with it.
    2. Getting a good job depends mainly on being in the right place at the right time.

12. 1. The average citizen can have an influence in government decisions.
    2. This world is run by the few people in power, and there is not much the little guy can do about it.

13. 1. When I make plans, I an almost certain that I can make them work.
    2. It is not always wise to plan too far ahead because many things turn out to be a matter of good or bad fortunes anyhow.

14. 1. There are certain people who are just no good.
    2. There is some good in everybody.

15. 1. In my case getting what I want has little or nothing to do with luck.
    2. Many times we might just as well decide what to do by flipping a coin.

16. 1. Who gets to be the boss depends on who was lucky enough to be in the right place first.
    2. Getting people to do the right thing depends upon ability, luck has little or nothing to do with it.

17. 1. As far as world affairs are concerned, most of us are the victims of forces we can neither understand, nor control.
    2. By taking an active part in political and social affairs the people can control world events.

18. 1. Most people don't realize the extent to which their lives are controlled by accidental happenings.
    2. There really is no such thing as "luck."

19. 1. One should always be willing to admit mistakes.
2. It is usually best to cover up one's mistakes.

20. 1. It is hard to know whether or not a person really likes you.
2. How many friends you have depends upon how nice a person you are.

21. 1. In the long run the bad things that happen to us are balanced by the good ones.
2. Most misfortunes are the result of lack of ability, ignorance, laziness, or all three.

22. 1. With enough effort we can wipe out political corruption.
2. It is difficult for people to have much control over the things politicians do in office.

23. 1. Sometimes I can't understand how teachers arrive at the grades they give.
2. There is a direct connection between how hard I study and the grades I get.

24. 1. A good leader expects people to decide for themselves what they should do.
2. A good leader makes it clear to everybody what their jobs are.

25. 1. Many times I feel that I have little influence over the things that happen to me.
2. It is impossible for me to believe that chance or luck plays an important role in my life.

26. 1. People are lonely because they don't try to be friendly.
2. There's not much use in trying too hard to please people, if they like you, they like you.

27. 1. There is too much emphasis on athletics in high school.
2. Team sports are an excellent way to build character.

28. 1. What happens to me is my own doing.
2. Sometimes I feel that I don't have enough control over the direction my life is taking.

29. 1. Most of the time I can't understand why politicians behave the way they do.

2. In the long run the people are responsible for bad government on a national as well as on a local level.

APPENDIX C

INTERNAL CONTROL INDEX (ICI)

Directions:

Please read each statement. Where there is a blank, decide what your normal or usual attitude, feeling or behavior might be:

(A) RARELY	(B) OCCASIONALLY	(C) SOMETIMES	(D) FREQUENTLY	(E) USUALLY
(Less than 10% of the time)	(About 30% of the time)	(About half of the time)	(About 70% of the time)	(More than 90% of time)

Of course, there are always situations in which this would not be the case, but think of what you would do or feel in most normal situations.

1. When faced with a problem, I ___try to forget it.

2. I ___need frequent encouragement from others for me to keep working at a difficult task.

3. I ___like jobs where I can make decisions and be responsible for my own work.

4. I ___change my opinion when someone I admire disagrees with me.

5. If I want something, I ___work hard to get it.

6. I ___prefer to learn the facts about something from someone else rather than have to dig them out for myself.

7. I will ___accept jobs that require me to supervise others.

8. I ___have a hard time saying "no" when someone tries to sell me something I don't want.

9. I ___like to have a say in any decisions made by any group I'm in.

10. I ___consider the different sides of an issue before making any decisions.

11. What other people think ___has a great influence on

my behaviour.

12. Whenever something good happens to me, I ___feel it is because I've earned it.

13. I ___enjoy being in a position of leadership.

14. I ___need someone else to praise my work before I am satisfied with what I have done.

15. I am ___sure enough of my opinions to try to influence others.

16. When something is going to affect me, I ___learn as much about it as I can.

17. I ___decide to do things on the spur of the moment.

18. For me, knowing I've done something well is ___more important than being praised by someone else.

19. I ___let other people's demands keep me from doing things I want to do.

20. I ___stick to my opinions when someone disagrees with me.

21. I ___do what I feel like doing, not what other people think I ought to do.

22. I ___get discouraged when doing something that takes a long time to achieve results.

23. When part of a group, I ___prefer to let other people make all the decisions.

24. When I have a problem, I try____follow the advise of friends or relatives.

25. I ___enjoy trying to do difficult tasks more than I enjoy trying to do easy tasks.

26. I ___prefer situations where I can depend on someone else's ability rather than just my own.

27. Having someone important tell me I did a good job is ___more important to me than feeling I've done a good job.

28. When I'm involved in something, I ___try to find out all I can about what is going on even when

someone else is in charge.

APPENDIX D

COOPERSMITH SELF-ESTEEM INVENTORY (CSI)

1. Things usually don't bother me.
2. I find it very hard to talk in front of a group.
3. There are lots of things about myself I'd change if I could.
4. I can make up my mind without too much trouble.
5. I'm a lot of fun to be with.
6. I get upset easily at home.
7. It takes me a long time to get used to anything new.
8. I'm popular with persons my own age.
9. My family usually considers my feelings.
10. I give in very easily.
11. My family expects too much of me.
12. It's pretty tough to be me.
13. Things are all mixed up in my life.
14. People usually follow my ideas.
15. I have a low opinion of myself.
16. There are many time when I would like to leave home.
17. I often feel upset with my work.
18. I'm not as nice looking as most people.
19. If I have something to say, I usually say it.
20. My family understands me.
21. Most people are better liked than I am.

22. I usually feel as if my family is pushing me.

23. I often get discouraged with what I am doing.

24. I often wish I were someone else.

25. I can't be depended on.